“She’s my best friend and I trust her with my life”: A mixed-methods exploration of peer support for personal problems in adolescence and how schools can help.

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Abstract

Research has shown that when young people experience difficulties in their lives, they rely on their friends for support. In the context of an increasing awareness of young people's mental health, this study examined the phenomenon of peer support among adolescents for personal problems, including serious problems relating to mental ill health. The aims of the study were to:

- explore how adolescent peers support one another with personal problems, including mental illness;
- explore why adolescents might prefer to disclose personal problems to peers;
- explore adolescents' perceptions of school-based peer support interventions (PSIs); and
- inform the future development and implementation of a PSI which adolescents perceive to be useable and effective.

The research comprised two phases. Taking a pragmatist approach, I used a combination of traditionally quantitative and qualitative research methods.

Phase 1 comprised a confirmatory methodology, using a self-administered questionnaire delivered to 390 Year 9 students at three secondary schools in a local authority in the West Midlands. Data were analysed using descriptive and inferential statistics and basic content analysis. Part A of the questionnaire elicited data to answer research questions relating to disclosures of personal problems that the participants had received from peers. The results showed that a high proportion of participants regularly discuss problems with peers across a range of domains. The participants had experienced disclosures of problems from friends both online and face-to-face, with females reporting a higher proportion of face-to-face disclosures than males.

Part B of the questionnaire presented vignettes of a peer disclosing a difficulty relating to mental illness: depression, anxiety, or self-harm. Each vignette was followed by questions to elicit participants' responses to the disclosure. Participants generally responded positively. Two thirds of the participants encouraged the friend to tell an adult about the problem, and half asked the friends experiencing depression or self-harm if they had considered suicide. The most commonly reported action was to tell an adult: Family members and school

staff were the most frequently specified adults. Participants were moderately confident in responding to the vignettes.

Phase 2 comprised an exploratory methodology, using a qualitative research approach: six focus groups with Year 9 students (N = 32) at three secondary schools. In the focus groups, the participants discussed the advantages and disadvantages of three types of PSI, facilitated by the researcher. They were also asked to discuss why they might choose to disclose a problem to a friend, rather than an adult. Data were analysed using thematic analysis.

Participants considered the following things when deciding in whom to confide a personal problem: confidentiality, motivation for listening to the problem, understanding of the problem, and feeling comfortable around the disclosee. They reported that PSIs should: be age-appropriate, confidential, and well-used; have a broad impact; involve a high quality of support; avoid unintended negative consequences; and respect the wishes of some young people not to share their problems.

Links are made between the two phases, and implications for schools and educational psychologists are considered. The thesis concludes with future directions for study, and the relevance of the findings for the mental health of young people in secondary schools.

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List of Abbreviations

Abbreviation	Meaning
APA	American Psychiatric Association
BPS	British Psychological Society
CASP	Critical Appraisal Skills Programme
DfE	Department for Education
DoH	Department of Health
DSM-V	Diagnostic and Statistical Manual of Mental Disorders Fifth Edition
EP	Educational psychologist
GDPR	General Data Protection Regulation
LA	Local authority
MHFA	Mental health first aid
MHL	Mental health literacy
NHS	National Health Service
NICE	National Institute of Health and Care Excellence
PHE	Public Health England
PSI	Peer support intervention
RQ	Research question
RSPH	Royal Society for Public Health
SD	Standard deviation
SENCo	Special Educational Needs Coordinator
SEYLE	Saving and Empowering Young Lives in Europe
WHO	World Health Organisation
YAM	Youth Aware of Mental Health

1. Introduction

This thesis concerns adolescent disclosures of personal problems to peers. In it, I explore how adolescents support one another with personal problems, including problems relating to mental ill health. I consider the role of schools in this phenomenon by gaining the views of young people about school-based peer support interventions (PSIs). This section sets out the rationale for focusing on the mental health and wellbeing of adolescents, and the context of young people's mental health in the UK. The role of schools in supporting pupils' mental health is then explored, including the use of PSIs. I then outline my personal interest in the topic. Definitions of mental health and wellbeing are interrogated further in Section 2.1.

1.1 A Focus on Adolescence

Adolescence has been identified as a critical period for improving outcomes across the lifetime (World Health Organisation [WHO], 2018). For adolescents worldwide, mental health issues are among the leading risk factors for death and disability (Gore et al., 2011), and half of all lifetime mental disorders start by the age of fourteen (WHO, 2018). The Health Foundation described adolescence as a life-defining period, when the foundations for a healthy future are laid, including mental health (Kane & Bibby, 2018). Public Health England (PHE, 2015) identified young people aged 10-24 as a priority group for improving life outcomes, due to adolescence being a stage of significant neural, emotional, and physical development. During adolescence, major changes occur in emotional and cognitive functions, and there is some evidence from brain imaging studies to suggest that the adolescent brain may be uniquely sensitive to stress (Romeo, 2017). Romeo (2017) acknowledged that there are significant limitations in this field, such as the lack of studies directly comparing the effects of chronic stress on adolescent and adult human brains. However, he noted that the notion of adolescence as a uniquely stress-sensitive period may help to explain the increase in stress-related psychiatric disorders in adolescence.

PHE's (2015) framework for improving the wellbeing of young people in England highlighted the importance of relationships. The Health Foundation also stressed the centrality of social networks to the physical and mental health of young people

(Kane & Bibby, 2018). There is evidence from neuroimaging and behavioural studies that relationships and social networks become increasingly important in adolescence; it may be a sensitive period for acquiring and processing sociocultural information (Blakemore & Mills, 2014). Social relationships during adolescence may also affect the development of "social brain" systems and could be implicated in the development of mental illness (Lamblin, Murawski, Whittle, & Fornito, 2017). Peer relationships – a key focus of this thesis – are therefore likely to be central to adolescents' mental health.

1.2 The National Context

UK policy.

The mental health of children and young people in the UK has gained unprecedented attention in recent years (Faulconbridge et al., 2017). The *Future in Mind* report (Department of Health [DoH] & National Health Service [NHS] England, 2015) outlined a number of proposals to improve children's mental health services, including promoting awareness of the issue. These proposals were subsequently incorporated into the *Five Year Forward View for Mental Health* document (Mental Health Taskforce, 2016): a plan to transform the approach to mental health within the NHS. It set out the government's commitment to transforming attitudes to mental health, with a shift towards prevention of mental illness. Children and young people were highlighted as a priority group for the promotion of mental health.

A recent green paper entitled *Transforming Children and Young People's Mental Health Provision* (DoH & Department for Education [DfE], 2017) set out further proposals to provide for children's mental health, with a focus on early intervention. A subsequent report criticised the green paper for failing to address factors causing mental health difficulties among children (House of Commons Education and Health and Social Care Committees, 2018).

UK trends and prevalence figures.

Alongside governmental policies, there has been a wealth of recent research exploring the mental health of young people in the UK. Research on service access indicators for Child and Adolescent Mental Health Services concluded

that the evidence suggested a rise in mental illness over the last fifteen years (Crenna-Jennings & Hutchinson, 2018). This trend has been reflected in a number of recent studies. A key limitation of such studies is that research and predictions were based on outdated prevalence data from 2004 (e.g. Frith, 2016; Viner, Ward, Cheung, Wolfe, & Hargreaves, 2018). Trends can also be explained by other factors, such as: greater awareness of mental health issues resulting in higher self-reports of mental health difficulties (e.g. Mental Health Foundation, 2017); changes in help-seeking behaviour; and increased access to mental health professionals (Sadler, Vizard, Ford, Goodman, et al., 2018).

Recently published statistics utilised a more reliable method of measuring the mental health of children in England: a large-scale survey of the general population identifying specific symptoms, to screen for diagnosable mental illnesses (Sadler, Vizard, Ford, Goodman, et al., 2018). The data from this study showed a slight upward trend in the prevalence of emotional disorders since previous studies in 1999 and 2004. In 2017, emotional disorders were the most common mental illness in 11-15 year-olds, compared with behavioural and hyperactivity disorders (Sadler, Vizard, Ford, Marcheselli, et al., 2018). Prevalence rates for emotional disorders were higher for girls than for boys, and anxiety disorders were more common in this age group than depressive disorders (Sadler, Vizard, Ford, Marcheselli, et al., 2018). Whilst these data demonstrated the prevalence of diagnosable mental illnesses among children in England, they did not provide insight into more general wellbeing.

Other studies have used broader measures of wellbeing to identify trends in the mental health of children in England. The mean life satisfaction of children aged 11-14 in England was consistently at the lower end compared to EU15 countries, across the period 2001-2014 (Viner et al., 2018). The *Good Childhood Report* – a large-scale study of children's subjective wellbeing in the UK – found that after a period of increasing wellbeing between 1995 and 2010, children's wellbeing is now as low as it was two decades ago (Children's Society, 2018). Outcomes for girls were particularly poor in this study: They were unhappier with their lives than boys, and twice as likely to self-harm. Brooks, Chester, Klemera, and Magnusson (2017) conducted an analysis of data from the 2014 Health Behaviour in School-aged Children study in England, with a focus on the wellbeing of adolescent girls. They found that across a range of indicators of emotional health and wellbeing,

girls reported poorer outcomes than boys, with the gap widening between the ages of 11 and 15.

1.3 The School Context

The role of schools.

A number of recent publications have examined the effects of mental health and wellbeing on education. In a review of the Avon Longitudinal Study of Parents and Children data, Gutman and Vorhaus (2012) found that children with higher levels of wellbeing aged 7-13 had higher levels of academic achievement and were more engaged in school aged 11-16. As children progressed through their education, their emotional and behavioural wellbeing became increasingly important in explaining school engagement. This study identified a correlational rather than a causational relationship. A review of studies examining the link between wellbeing and educational outcomes highlighted the difficulty of drawing conclusions about causality, but outlined key evidence demonstrating that pupils with better wellbeing are likely to achieve better academically (PHE, 2014).

Schools have been gaining increasing attention in policy and research for their essential role in the development of young people's mental health and wellbeing (e.g. DfE, 2018; Frith, 2016; House of Commons Education and Health Committees, 2017; Marshall & Smith, 2018; National Institute for Health and Care Excellence [NICE], 2018; Thorley, 2016). The *Future in Mind* report (DoH & NHS England, 2015) highlighted the importance of promoting positive mental wellbeing at school. The recent green paper emphasised the role of schools in identifying and supporting children with mental health difficulties (DoH & DfE, 2017). Government guidance for schools in supporting pupils' mental health has also been published (NatCen Social Research & National Children's Bureau Research and Policy Team, 2017). This guidance recommended that schools normalise mental health issues, raise awareness of avenues of support, and act as hubs for early identification of difficulties.

Mental health and wellbeing: peer support.

Student consultation took place in England for the recent green paper on transforming children's mental health (Department of Health and Social Care & Young Minds, 2018). A key theme was the role of peers in improving mental health at school. PSIs are common in schools as interventions intended to support pupils' mental health (Coleman, Skyes, & Groom, 2017; DfE, 2011).

PSIs are based on the assumption that young people may prefer to receive support for their problems from peers, rather than adults. This notion is supported by research about self-disclosure and help-seeking in adolescence, as described in Section 2.3. During adolescence, young people disclose less to their parents and make more intimate disclosures to friends (Solis, Smetana, & Comer, 2015). Adolescents also rely primarily on friends for help and support in difficult times (Evans, Hawton, & Rodham, 2005). Adolescents might therefore prefer to seek help with problems using a school-based PSI than by approaching an adult. There is a lack of research, however, into young people's attitudes towards existing types of PSI, and the range of personal problems discussed between adolescent peers.

1.4 Personal Interest

Prior to the DEdPsych course, my professional experience was primarily in supporting adolescents at secondary school. I developed an interest in peer influences, as I often observed how the dynamics of a class could affect pupils' engagement with learning. I wondered which other spheres of life were affected by peer relationships in this formative period.

While studying for a Masters of Education at the University of Bristol, I worked on an assignment investigating the neuroscientific basis of the increased influence of peers in adolescence. My dissertation investigated the social influences on adolescents' decision-making about post-16 education and training. I found that peers played a prominent role in bringing young people to these potentially life-changing decisions.

The current study was inspired by a presentation on self-harm on the DEdPsych course, in which I learned that peers were the primary sources of support for adolescents who had self-harmed. I remembered having friends who self-harmed

at school and university, and my internal conflict over whether this was “normal” behaviour, whether I should attempt to intervene, and what I should do if I chose to act on this knowledge. Receiving a serious disclosure from a peer could be a huge responsibility, and I wondered whether adolescents were equipped to deal with it. I decided to investigate the phenomenon of peer disclosures further, through the broader lens of general problems affecting young people’s mental health and wellbeing.

2. Literature Review

This section reviews literature on how adolescents seek support when experiencing personal problems, including help from peers. It covers:

- the definitions of mental health, wellbeing, and personal problems that will be used in this thesis;
- literature on adolescents' help-seeking behaviours, including barriers to help-seeking;
- adolescent peer relationships, including the role of peers in support for personal problems;
- online help-seeking;
- gender differences relating to disclosures of problems between adolescent peers;
- school-based interventions to support mental health, including universal education programmes and PSIs;
- reasons for including some universal education programmes under an expanded definition of PSIs; and
- young people's views on school-based interventions.

The literature search was conducted electronically using the EBSCO, Science Direct, ERIC and PsychINFO databases, and the journals *Educational Psychology in Practice* and *Educational and Child Psychology*. Key words and phrases searched included: *adolescent(s)*, *adolescence*, *stressors*, *personal problems*, *peer support*, *mental health*, *wellbeing*, *help-seeking*, *secondary school*, *self-disclosure* and *peer support intervention*. The search was limited to articles that were: in the English language; published from the year 2008 onwards; accessible using University of Exeter credentials; and based in Europe, Canada, the USA and Australia. Articles were selected based on their relevance to the research focus. Reference sections of selected papers were used to identify additional literature. Articles published before 2008 were included if central to the research focus. I also accessed relevant online government publications and voluntary organisation websites.

2.1 Definitions and Frameworks

Mental health and wellbeing.

This research concerns discussions among adolescent peers regarding personal problems. I consider personal problems to operate within a framework of wellbeing and mental health, the definitions of which are broad-ranging and largely unresolved within current psychological research (Dodge, Daly, Huyton, & Sanders, 2012; Keyes, 2002). For this research, Keyes's (2002, 2005) framework of a *mental health continuum* was adopted.

Challenging the traditional conceptualisation of mental health as an antonym of mental illness, Keyes (2002) described mental health as a "syndrome" of subjective wellbeing, including positive feelings and positive functioning. The continuum of mental health ranges from "flourishing" to "languishing" (p. 208). The model combines emotional wellbeing (positive feelings about life) with psychological wellbeing (e.g. self-acceptance and autonomy) and social wellbeing (e.g. social integration and contribution).

This model addresses a key debate within psychological research on wellbeing: the relationship between the philosophical traditions of hedonism (maximising pleasurable moments) and eudaimonia (living a life of virtue and achieving one's potential) (Henderson & Knight, 2012). Keyes (2002, 2005) considered hedonism and eudaimonia to be distinctive concepts: that is, the difference between feeling (emotional wellbeing) and functioning (psychological and social wellbeing) respectively. Both play a role in an individual's position on the mental health continuum. Individuals with moderate mental health (between languishing and flourishing) can have high or low levels of hedonic wellbeing, with implications for their overall functioning in society (Keyes & Annas, 2009).

This study addresses both hedonic and eudaimonic wellbeing. According to Keyes (2005), hedonic symptoms of mental health include happiness and satisfaction with particular domains of life. Personal problems within those domains are likely to decrease satisfaction, thus affecting hedonic wellbeing and driving the individual down the mental health continuum. This study also explores the sharing of problems within peer relationships; positive relations with others is a eudaimonic symptom of mental health (Keyes, 2005). Therefore, this research examines potential threats to hedonic wellbeing (personal problems negatively

affecting satisfaction with domains of life) in the context of one element of eudaimonic wellbeing (personal relationships with others).

Personal problems.

I was unable to find a definition of *personal problems* in existing literature; research in this area tends to refer to *stressors*. Stressors have been defined as "environmental events or chronic conditions that objectively threaten the physical and/or psychological health or well-being of individuals of a particular age in a particular society" (Grant et al., 2003, p. 449). Studies in this area commonly examine the relationship between stressors, coping styles, and symptoms of psychopathology (such as Bratlien et al., 2014; Cicognani, 2011; Eppelmann et al., 2016). Such studies tend to operate within a psychopathological model of mental health, in which mental health is operationalised as the absence of mental illness (Keyes, 2002, 2005).

This study uses the term *personal problems* rather than *stressors*, as it encompasses a broader spectrum of difficulties with which a young person might seek help. Personal problems are likely to overlap with stressors (as defined by Grant et al., 2003), but extend to non-environmental problems, such as the experience of mental illness. Unlike proponents of psychopathological models of mental health, Keyes (2002, 2005) stated that mental illness (i.e. the presence of diagnosable mental disorders) is not at the opposite end of the spectrum to mental health: It is a separate dimension which may affect mental health but does not define it. The presence of mental illness might be experienced as a personal problem affecting life satisfaction, thereby driving the individual further down Keyes's (2002, 2005) mental health continuum.

Summary.

This study works on the following assumptions.

- Mental health can be operationalised as a continuum. An individual's position on the continuum is determined by the combination of positive feelings and positive functioning.
- One element of positive functioning (or eudaimonic wellbeing) is having trusting relationships with others.

- Positive feelings (or hedonic wellbeing) include satisfaction with domains of life; this can be threatened by the experience of problems in these domains.
- An individual's position on the mental health continuum can therefore be affected by the experience of personal problems.
- Personal problems can include environmental and non-environmental problems, such as the experience of mental illness.
- Mental illness does not constitute the opposite of mental health; however its occurrence may be a personal problem which affects one's position on the mental health continuum.

2.2 Adolescents Seeking Help

Help-seeking and self-disclosure.

There is a large body of research on young people's help-seeking behaviours relating to mental health. The WHO defined help-seeking behaviour as "any action or activity carried out by an adolescent who perceives herself/himself as needing personal, psychological, affective assistance or health or social services, with the purpose of meeting this need in a positive way" (Barker, 2007, p. 2). This includes seeking help from both formal and informal sources. "Help" includes the provision of informal emotional support (Barker, 2007). Therefore, self-disclosure of a problem can be conceptualised as informal help-seeking. Self-disclosure is the exposure of intimate information about oneself (Misoch, 2015). Some researchers define help-seeking as a combination of self-disclosure and intention to seek help (Pisani et al., 2012). However, I conceptualise self-disclosure as a form of help-seeking in itself, as it is likely to elicit emotional support and may lead to support from other sources.

A literature search on help-seeking in adolescence produced studies which almost exclusively examined help-seeking for mental illness. Much of the literature in this section therefore relates to help-seeking for diagnosable mental illnesses. These studies were relevant to the current research, since mental illness may be a personal problem affecting an individual's position on the mental health continuum. However, there were few studies on more general personal problems experienced in adolescence.

Barriers to help-seeking in adolescence.

Stigma is an established barrier to seeking help for mental illness. Gulliver, Griffiths, and Christensen (2010) conducted a systematic review of research on barriers to and facilitators of mental health-related help-seeking in young people. The most prominent barrier was perceived stigma of those from whom help might be sought. A systematic review of the impact of the help-seeker's own mental health-related stigma (for individuals of any age) found that stigma had a small to moderate sized negative effect on help-seeking (Clement et al., 2015). However, a recent study with adolescents in Ireland showed that perceived public stigma was a stronger predictor of help-seeking intentions for depression than the individual's own stigma beliefs (Nearchou et al., 2018). Perceiving school staff as unsupportive also presented a barrier to adolescents seeking help from an adult for bullying or threats of violence (Eliot, Cornell, Gregory, & Fan, 2010).

Concerns about confidentiality and disclosure have also been identified as a key barrier to people seeking professional help for mental illness. In Clement et al.'s (2015) review, confidentiality concerns were the most commonly reported barrier to help-seeking for mental illness at any age. Qualitative studies of help-seeking with young people support this finding. Focus group interviews with adolescents in Northern Ireland explored attitudes to consulting a GP about psychological problems. The researchers found that a pervasive lack of trust was a major barrier to help-seeking from GPs, due to: limited prior contact with the GP, anxiety about approaching a GP, and concerns about confidentiality and parental involvement (Corry & Leavey, 2017). Interviews with young people in London who had self-harmed revealed that teachers and school staff were not trusted sources of support, because they were perceived as likely to share the disclosure with others (Klineberg, Kelly, Stansfeld, & Bhui, 2013). These barriers to seeking help from professionals can be interpreted as reasons to seek help from a peer instead: somebody who is known to the young person and possibly more likely to promise confidentiality. Indeed, Corry & Leavey (2017) found that most participants preferred to talk with parents or a friend.

Poor mental health literacy (MHL) is another barrier to adolescents seeking help (Gulliver et al., 2010). MHL comprises the knowledge and beliefs about mental illnesses which aid their recognition, management, and prevention (Jorm et al., 1997). A number of measures of MHL have been developed, usually to establish

whether individuals can correctly identify diagnosable mental illnesses. These have included psychometrically tested questionnaires for the general public (Evans-Lacko et al., 2010; Jung, von Sternberg, & Davis, 2016) and the use of vignettes to assess the MHL of young people (Byrne, Swords, & Nixon, 2015; Burns & Rapee, 2006; Coles et al., 2016; Marshall & Dunstan, 2013).

Marshall and Dunstan (2013) used written and dramatised vignettes to examine young people's knowledge about depression, including identification, predicted recovery times, and avenues of assistance. The vignettes were adapted from the Friend in Need Questionnaire developed by Burns and Rapee (2006), which examined the ability of young people to recognise and label depression in a peer. Coles et al. (2016) also used an adapted version of the Friend in Need Questionnaire to examine whether a large sample of adolescents in the USA could correctly label instances of depression and social anxiety disorder in peers. The researchers acknowledged that the limited ability of participants to recognise these mental illnesses may have been due to their strict criteria for correct recognition. They also reflected that if somebody misclassifies their peer's symptoms, but nevertheless facilitates help-seeking, the incorrect labelling of the friend's condition may be unimportant.

Therefore, whilst studies on MHL have previously focused on correct identification of mental illnesses according to diagnostic criteria, there are arguably more important elements of MHL. This includes awareness of when to seek adult help on behalf of a peer. The concept of *literacy* might also be applied to knowledge and beliefs about other personal problems with which a peer might require support.

2.3 Peer Support in Adolescence

Adolescent peer relationships.

Research shows that during adolescence, intimate peer relationships become increasingly prevalent. Developmental tasks of adolescence include the achievement of emotional independence from parents and mature relationships with peers (Nurmi, 2004). In the context of horizontal relationships (i.e. less hierarchical than relationships with adults, for instance), adolescents learn valuable interpersonal skills (Coleman & Hendry, 1999). Adolescent peer

relationships tend to become intense and more complex: Friendships are characterised less by shared activities and more by trust, including the sharing of secrets, worries, and ambitions (Brown, 2004). Erikson's theory of psychosocial development also characterises adolescence as a time of increased involvement with social groups with whom the individual identifies (Erikson, 1968).

These theories are consistent with research showing that with age, adolescents disclose less to parents, while their friendships become more central, and intimate disclosures to friends increase. Using a diary-analysis methodology to study adolescent secrecy in the USA, Solis et al. (2015) found that participants disclosed more to and kept fewer secrets from their best friends than their mothers. Perkins and Turiel (2007) used vignettes to show that adolescents in the USA found it more acceptable to deceive parents than friends about moral and personal issues. The researchers claimed that this supports the idea that self-disclosure and trust are essential to adolescent friendships. As a result, adolescents may be likely to confide in a peer when experiencing a personal problem.

Peer support in difficult times.

Consistent with theories of adolescent psychosocial development, research has shown that adolescents rely primarily on their friends for help in difficult times. In a large-scale study of coping strategies, communication, and help-seeking in English adolescents, Evans et al. (2005) demonstrated the extent to which adolescents use their friends for support. Participants were asked whom they felt they could talk to about things that really bother them: The most frequent answer (84.7% of respondents) was "a friend." About three quarters of adolescents who had engaged in self-harm had told a friend about what they had done on the last occasion of self-harm. As well as telling friends about self-harm, many adolescents rely on peers for support. A similar study with a comparable sample found that 40% of participating adolescents who had self-harmed used friends as the main source of support (Fortune, Sinclair, & Hawton, 2008). The research therefore suggests that adolescents are likely to involve peers when experiencing serious personal problems such as self-harm.

This reliance on peers is supported by other studies of adolescent help-seeking. Reichardt (2016) interviewed five adolescents who had self-harmed; they

discussed their increased dependence on peers for support and guidance during the period of self-harm. Leavey, Rothi, and Paul (2011) found that in a sample of adolescents in London, friends were listed as the most likely source of support for difficulties with anxiety and depression. Pisani et al. (2012) found that students were twice as likely to disclose suicidal intentions to peers than to adults. Priebe and Svedin (2008) also found that almost half of their participants (adolescents in Sweden) who had experienced sexual abuse confided only in a peer. After "family members," "friends" was the second most common response when a representative sample of young people at secondary schools in England were asked with whom they would feel most comfortable discussing their mental health (Lindley, Clemens, Knibbs, Stevens, & Bagge, 2019). These studies tended to rely on theories of adolescent friendships to explain their findings; no recent research was found on why adolescents perceive friends to be a valuable source of support for personal problems.

Benefits and costs of seeking help from peers.

It has not been clearly established whether seeking help from peers is beneficial for adolescents. A systematic review and meta-analysis found only a small number of studies directly measuring the association between help-seeking from informal sources and psychosocial outcomes during adolescence (Heerde & Hemphill, 2018). Nevertheless, the findings showed that help-seeking from informal sources may reduce the likelihood of poor psychosocial outcomes among adolescents. The review included peers, family members, and other supportive adults as informal sources of support, rather than specifically measuring the effect of seeking help from peers.

In one study, adolescents' communication with friends, including co-rumination, decreased the likelihood of self-harming behaviours (Latina, Giannotta, & Rabaglietti, 2015). Co-rumination is the excessive discussion of personal problems and has been linked to positive and negative outcomes for adolescents (Rose, 2002). Latina et al.'s (2015) study showed that co-rumination with a friend decreased the likelihood of self-harming but did not moderate the relation between depressive symptoms and self-harm. That is, talking about problems with a best friend appeared to help adolescents not to engage in self-harm, but did not offer an alternative coping mechanism to self-harm when depressive

symptoms were present. Vélez et al. (2016) found that social support-seeking predicted fewer symptoms of depression and anxiety at low rumination levels, but not at higher levels. These findings imply that peers alone may not provide effective support to young people for serious problems.

Furthermore, the disclosure of a personal problem may incur costs or benefits in the social context of adolescent friendships. The culture and composition of preadolescent and adolescent friendship groups can be unstable (Adler & Adler, 1995; Poulin & Chan, 2010). Making oneself vulnerable to ridicule, for example by disclosing a potentially stigmatising problem, could lead to a reduction in status and power within the friendship group (Adler & Adler, 1995). Peer victimisation in adolescence is increasingly characterised by relational aggression, such as spreading rumours with the intention of lowering the individual's status with their peers (Troop-Gordon, 2017). Sharing personal problems could make adolescents vulnerable to this form of aggression. Corsano, Musetti, Caricati, and Magnani (2017) found a strong negative association between adolescents' tendency to keep secrets from friends and self-esteem. They hypothesised that a desire to be socially accepted by peers led some adolescents to conceal characteristics and behaviours that they perceived as undesirable. This suggests that young people may choose to hide personal problems, to avoid negative social consequences.

On the other hand, sharing secrets within adolescent friendships may have social benefits. In a functional analysis of secret-sharing among Dutch adolescents, Frijns, Finkenauer, and Keijsers (2013) found that sharing a secret with at least one person was linked to a higher quality of relationship with the disclosee, as well as lower levels of loneliness and higher interpersonal competence. Although the cross-sectional design of the study limits the possibility of inferring the causal direction of these associations, the researchers suggested that secret-sharing is an important skill in attaining and maintaining intimacy in adolescent friendships.

There may also be gender differences in the impact of disclosing personal problems within adolescent friendships. There is a well-established research base showing that adolescent females tend to disclose more to friends than males (Buskirk-Cohen, 2012; Corsano et al., 2017; Poulin & Chan, 2010). Adolescent females has also been found to have more developed emotional understanding and higher empathy than males (Białecka-Pikul, Kołodziejczyk, &

Bosacki, 2017; Wölfer, Cortina, & Baumert, 2012). Goede, Branje, and Meeus (2009) found that issues relating to power and status are more prominent within male adolescent friendships, which may make it more difficult for males to display vulnerability by disclosing problems to friends. This large-scale study of adolescents in the Netherlands also found that girls perceived their friendships as more supportive than males throughout adolescence. These findings imply that adolescent females may be more likely than males to disclose personal problems, and may respond to disclosures with more empathy and support.

Attitudes to peer disclosures of personal problems.

Facilitators for young people seeking professional help for mental health difficulties include encouragement from others, social support, and positive past experiences of help-seeking (Gulliver et al., 2010). Since many young people initially disclose such problems to friends, it is important that this experience is positive.

Adolescents' attitudes towards peer disclosures of personal problems are therefore of importance. Klineberg et al. (2013) conducted interviews with 10 non-self-harming adolescents, to explore attitudes towards self-harming peers and to provide insight into potential peer responses to disclosures of self-harm. The participants made some disparaging comments, such as interpreting self-harm as attention-seeking. They also viewed self-harm as acceptable if hidden from others. Whilst this study was conducted on a small scale, the findings suggest that adolescents may not respond positively to a peer disclosing self-harm. Indeed, self-harming adolescents in the same study reported negative experiences of peers discovering their self-harm, such as focus on physical injury and little emotional support.

Stigma influences not only adolescents' willingness to seek help for a personal problem (Gulliver et al., 2010), but also their responses to a peer's disclosure of mental illness. Adolescents with mental illnesses in the USA reported stigmatisation after disclosing their difficulties to peers, often leading to friendship losses and transitions (Moses, 2010). Some participants had chosen to conceal their problems from peers to protect their relationships. Yap and Jorm (2011) also found that in a large sample of Australian adolescents, young people's

stigmatising attitudes predicted less helpful actions towards a peer who disclosed a mental illness.

Actions in response to peer disclosures.

In the literature search, only three studies were identified relating to adolescents' actions in response to a peer's disclosure of a serious personal problem such as mental illness; none of the studies were with a UK-based sample. Consistent with the medical terminology frequently used throughout literature on mental health, actions taken in response to somebody else's mental health difficulties are often referred to as *mental health first aid* (MHFA). Yap, Wright, and Jorm (2011) asked adolescents in Australia what actions they had taken to support a close friend or family member with a mental health difficulty. They found that most participants reported taking some helpful actions, such as encouraging professional help-seeking, listening supportively, and providing social support. However, less helpful actions were also reported, including talking to the person firmly and not assessing suicide risk. A similar study of older adolescents in Ireland (mean age of 17) also found limitations in responses to a friend displaying signs of depression, such as not assessing suicide risk or engaging adult help (Byrne et al., 2015).

Similarly, Mason, Hart, Rossetto, and Jorm (2015) examined the quality of MHFA intentions and actions in a moderately-sized sample of Australian adolescents. They judged the quality of MHFA actions using findings from a Delphi study which identified key messages for adolescents responding to somebody experiencing a mental health crisis (Ross, Hart, Jorm, Keppy, & Kitchener, 2012). They found that most participants mentioned at least one helpful MHFA action, but that the overall quality of MHFA intentions and actions was poor. The researchers acknowledged that brief responses were not able to be scored, so the results may not have fully reflected participants' knowledge of the appropriate actions.

Impact of a peer's disclosure on the disclosee.

There is little research examining the potential impact of receiving a peer's disclosure of a serious problem. Studies tend to highlight potential risks to the disclosee, such as the *contagion effect*: that exposure to self-harm and suicide in

others is associated with adolescent self-harm (Hawton, Saunders, & O'Connor, 2012). Reichardt (2016) also suggested that when adolescents who self-harm obtain help from peers, the discloser and disclosee may experience guilt, responsibility, and shame. The literature search found no empirical research investigating this concern or exploring the impact of peer disclosures of problems other than self-harm. No literature on adolescents' experiences of help-seeking was found from the perspective of the disclosee.

Seeking and receiving support online.

Young people are avid consumers of the internet: Ofcom (2019) showed that in 2018, 99% of 12-15 year-olds in the UK went online, and 69% had a social media profile. From the perspective of developmental psychology, Valkenburg and Peter (2011) proposed that some of the key tasks of adolescence are now enacted online. There is a wealth of literature on the relationship between young people's mental health and their use of the internet, particularly social media websites. Research identifies benefits and risks associated with internet use (Bentley, O'Hagan, Raff, & Bhatti, 2016; Frith, 2017; Royal Society for Public Health [RSPH], 2019). For example, young people can seek support for mental illness on social media, but thereby come across content which glamorises suicide and self-harm (RSPH, 2019). This topic has recently gained prominence in the media following the death of teenager Molly Russell, whose suicide was linked to content that she had been viewing online (Savage, 2019). The government has developed strategies for protecting young people from viewing harmful content online, focusing on the responsibility of platform providers to prevent and remove such content (Wright & Javid, 2019).

There is research exploring self-disclosure and help-seeking online. Evidence exists to suggest that adolescent help-seeking online may be qualitatively different to face-to-face help-seeking (e.g. Frison & Eggermont, 2015). Suler's (2004) theory of the *online disinhibition effect* is relevant to self-disclosure: that people say or do things online that they would not ordinarily say or do face-to-face. The theory includes benign online disinhibition (the sharing of personal information online) and toxic online disinhibition (the use of rude language, threats, and harsh criticism). Peers could therefore react positively or negatively to an adolescent's online disclosure of a personal problem.

There is inconsistency in existing research regarding the likelihood of adolescents responding supportively to personal problems disclosed online. Studies of online experiences of adolescents with mental illnesses identify the benign and toxic elements of online behaviour. In a qualitative study of the interaction between online social networking and the wellbeing of 12 young people accessing mental health services in the UK, participants experienced both "threats and judgement" and "connection and support" online (Singleton, Abeles, & Smith, 2016, p. 397). In a small-scale study of depressed adolescents' use of social media, participants discussed "oversharing" (updating too frequently or with too much personal information) and "stressed posting" (sharing negative updates; Radovic, Gmelin, Stein, & Miller, 2017, p. 7). These negatively-framed concepts suggest that disclosing problems online may be received negatively by peers.

Research on this topic relates to a variety of websites: As well as the wealth of research on social media, there is research on blogs (Hollenbaugh & Everett, 2013), video sharing sites (Misoch, 2015), and other internet forums (Murray & Fox, 2006). Much research is also conducted on young adults rather than school-aged adolescents (e.g. Jordán-Conde, Mennecke, & Townsend, 2014; Zhang, 2017). This may explain the inconsistency of results relating to the benefits and risks of online self-disclosure. There is a need to explore this phenomenon further, for example by identifying how often school-aged adolescents disclose personal problems online and what types of online platform they use.

Gender differences in seeking and receiving support from peers.

Many studies on adolescent help-seeking examine the influence of gender: Results vary between studies. Fortune et al. (2008) found no significant gender difference in the sources of help approached by adolescents who had self-harmed. This differs from research on more general coping strategies for stressors in adolescence: Consistent with previous research in this area, Herres (2015) found that females reported engaging in more coping strategies, including approach strategies (such as support-seeking), than boys. Fortune et al. (2008) found gender differences in perceptions of self-harm relevant to help-seeking: Female participants were more likely to consider self-harm as serious and requiring help, for example. This corroborates with Raviv, Raviv, Vago-Gefen,

and Fink's (2009) finding that adolescent girls tended to perceive emotional problems as more severe than boys and displayed greater willingness to seek help for themselves or others. However, Nearchou et al. (2018) found that adolescent boys showed significantly more willingness to seek help for self-harm than girls.

Psychological as well as biological aspects of gender may affect help-seeking. Gender role self-concept was implicated in a study of German adolescents' willingness to seek academic help: Identifying with negative aspects of masculinity such as aggression was associated with less willingness to seek academic help (Kessels & Steinmayr, 2013). Similarly, a Canadian study of male adolescents' help-seeking intentions demonstrated that boys who showed less conformity to masculine norms indicated higher intentions of seeking help from friends with general problems (Sears, Graham, & Campbell, 2009).

Gender may also influence adolescents' actions when helping a friend with a problem. Female adolescents have been shown to have higher MHL than males (Coles et al., 2016), although the extent of this gender difference in older young people (aged 17-22) was challenged by Furnham, Annis, and Cleridou (2014). Female adolescents were found to provide higher quality MHFA than males for hypothetical friends with a mental illness (Mason et al., 2015). Yap et al. (2011) also found that gender had a significant influence on MHFA behaviours: Females were more likely than males to provide social support and facilitate professional help-seeking to a friend or family member with a mental illness.

Help-seeking from peers for personal problems.

This section has shown that adolescents use their peer networks as sources of support for serious personal problems such as mental illness and self-harm. Existing studies of MHL and help-seeking tend to focus on diagnosable mental illnesses. However, adolescents are likely to disclose personal problems which would not meet thresholds for involvement from mental health services, but nevertheless require help of some kind. Whilst there are a number of studies examining the types of problems that adolescents encounter (e.g. Anniko, Boersma, & Tillfors, 2018; Byrne, Davenport, & Mazanov, 2007), no studies were found exploring the range of personal problems discussed between adolescent peers or the frequency of such discussions.

2.4 School-Based Interventions for Mental Health

Section 2.3 demonstrated that adolescents seek help from their peers with serious problems irrespective of the effectiveness and safety. Evans et al. (2005) and Priebe and Svedin (2008) concluded that adolescents should be educated on how best to help friends with problems such as self-harm and abuse, including advice on when they should seek help from an adult, even when it involves breaching confidentiality. I now examine how schools support pupils' mental health, including helping adolescents to support one another more effectively.

There is a range of school-based interventions to support the mental health of young people, including: gatekeeper training, screening tools to identify at-risk pupils, universal education programmes, and PSIs. In this section, the evidence on the effectiveness of each type of intervention is briefly outlined.

Gatekeeper training and screening tools.

Gatekeeper training is training for school staff on responding to students' mental health difficulties, such as MHFA England: a programme for school staff, currently funded in part by the DoH (MHFA England, 2018). Whilst gatekeeper training has been tentatively shown to improve staff attitudes and confidence (Kelly et al., 2011; Robinson et al., 2013), there is little evidence of direct impact on pupils' mental health. A gatekeeper training intervention was found to have no significant effect on suicide attempts in an international randomised controlled trial of interventions for suicide prevention: the Saving and Empowering Young Lives in Europe (SEYLE) study (D. Wasserman et al., 2015). Evans et al. (2005) found that just 20.8% of adolescents would confide a personal problem to a teacher. As a result, interventions focused on staff efficacy may not reach most young people experiencing problems affecting their mental health.

Screening programmes are designed to identify young people with mental health difficulties. A review of literature on suicide and self-harm in adolescents identified significant limitations to such programmes, due to the likelihood that one-off screeners will yield false negatives and positives, as suicide risk tends to fluctuate over time (Hawton et al., 2012). There were mixed results about the success of Profscreen, an intervention in which professionals screened at-risk pupils. The SEYLE study found no significant effect on adolescent suicide

attempts and suicidal ideation (D. Wasserman et al., 2015). However, the NICE (2015) review of suicide prevention programmes in schools suggested that Profscreen may have increased help-seeking behaviour. However, there is limited evidence that gatekeeper training and screening programmes have a direct impact on adolescents' mental health.

Universal education programmes.

Universal education programmes are interventions delivered directly to all pupils. In the SEYLE study, there was convincing evidence that such programmes affect mental health-related outcomes for young people (D. Wasserman et al., 2015). For example, Youth Aware of Mental Health (YAM) – a universal intervention which raised awareness about risk and protective factors associated with suicide – was associated with a significant reduction of suicide attempts and severe suicidal ideation at the 12-month follow-up, compared with a control group (D. Wasserman et al., 2015). YAM enabled participants to reflect on their experiences and develop problem-solving techniques (C. Wasserman, Hoven, & Wasserman, 2015). D. Wasserman et al. (2015) suggested that the pupils' active participation and personal engagement with the programme made the intervention more effective than the gatekeeper training and screening programme evaluated in the SEYLE study.

Other studies on universal interventions have not reflected this optimism (e.g. Dray et al., 2017). A systematic review of interventions to support adolescents' mental health concluded that there is no evidence that school-based suicide prevention programmes affect suicide-related attitudes or behaviours (Das et al., 2016). The SEYLE study was not included in this paper. Headstrong, a universal educational programme in Australia, was found to have no significant impact on participants' psychological distress or suicidal ideation (Perry et al., 2014). The researchers suggested that this may have been a result of low base rates; the study also had a significantly smaller sample size than the SEYLE study. Headstrong's follow-up evaluation was also conducted six months after the intervention; the impact of YAM was seen in the 12-month but not the three-month follow-up. It may be that such interventions take longer than expected to affect mental health outcomes.

How effective are PSIs?

The potential of peer support in improving adolescents' mental health has received attention in recent policy. A government document outlining whole-school approaches to promoting good mental health suggested that peer education or mediation approaches may help pupils to build positive relationships (Lavis & Robson, 2015). A green paper setting out intentions for mental health provision for young people proposed that peer support approaches could normalise mental illnesses and engage students in improving mental health (DoH & DfE, 2017).

Many schools provide PSIs for their students (Coleman et al., 2017; DfE, 2011). In the only identified review of existing PSIs, Coleman et al. (2017) defined peer support as: "Children and young people helping each other in a planned and structured way with training to enable them to fulfil their role(s)" (pp. 15-16). They identified the following types of peer support:

- school-based one-to-one support, in which trained peer supporters are matched with targeted individuals or provide ad hoc support through a drop-in system;
- school-based group support, in which older pupils deliver sessions to a group of pupils, or trained moderators deliver a session among a peer group;
- training-based projects, in which selected pupils receive training on mental health and wellbeing, to act as champions in the school;
- online projects; and
- community-based projects run by voluntary organisations.

Coleman et al.'s (2017) review of PSIs found mixed evidence of success: Few studies offered robust evaluation of the intervention. The authors nevertheless concluded that PSIs have potential to improve outcomes for young people, particularly self-reported outcomes such as happiness and self-esteem. This review included PSIs intended for pupils aged 4-18. Since adolescence is a potentially unique period of sociocultural change (Blakemore & Mills, 2014), interventions relating to peer relationships may need to be different at this stage of life. Furthermore, I argue below that a broader definition of school-based PSIs is needed, to account for the informal peer support that exists between adolescents without adult intervention.

Universal programmes for peer support.

Coleman et al.'s (2017) definition of peer support as "planned and structured" and involving "training" (pp. 15-16) overlooks the informal peer support that exists among adolescents without adult intervention. Peer support can be formal (involving a structure imposed by adults) or informal (without adult involvement). Universal programmes for peer support train all young people to better fulfil their existing role as informal peer supporters within their existing friendship networks.

Research suggests that universal programmes for peer support can be effective. The Helping Friends intervention in Australia built upon existing peer networks to improve the availability, accessibility, and appropriateness of social and personal support (Dillon & Swinbourne, 2007). It found small but significant increases in some subscales of the social provision scale, although these results can also be explained by a maturation effect, since there was no control group. YAM included sessions using role play to train young people how to listen to peers and how to speak about depression and suicidal thoughts, facilitated by an adult (C. Wasserman et al., 2015). Thus, whilst the participants were not supporting one another in a planned and structured way, they received an intervention to enable them to help their peers more effectively.

In the current study, any intervention relating to peer support is considered a PSI, including those which are intended to improve informal peer support. These will be referred to as *universal PSIs*.

2.5 Young People's Views on PSIs

Children and young people can give clear and varied opinions on aspects of school life (Todd, 2007). However, their participation in the development of school-based schemes can be tokenistic, with PSIs often implemented based on adult views of how such systems should function (Todd, 2007). Coleman et al.'s (2017) review found that one risk to the success of PSIs is low take-up of the scheme by pupils. Cowie and Oztug (2008) also concluded that one reason for PSIs having no effect on students' perceived safety at school was that there was no pupil evaluation of the schemes.

Whilst studies on individual PSIs sometimes gain participants' views (Coleman et al., 2017), there are few studies gaining adolescents' views on how they feel their

mental health could be supported in school (Atkinson et al., 2019). In UK-based studies, adolescents raise confidentiality, emotional support, and effectiveness as important (Kendal, Callery, & Keeley, 2011; Kendal, Keeley, & Callery, 2011). Atkinson et al. (2019) developed a whole-school mental health strategy in collaboration with secondary school students in Scotland. They found that the pupils were able to identify stressors affecting students and to create a student-friendly strategy. Kendal, Callery, and Keeley (2011) conducted focus groups with 54 adolescents from three UK secondary schools, to discuss the content, delivery, and evaluation of school-based support for emotional wellbeing. In the study, participants preferred adult to peer mentors: Peer mentors were considered less trustworthy and credible. Participants were not asked about any other forms of PSI.

The *Future in Mind* report (DoH & NHS England, 2015) recommended that the design and implementation of PSIs should be led by young people with professional support. In existing literature, there is a discrepancy between the negative perceptions of young people towards PSIs (Coleman et al., 2017; Kendal, Keeley, & Callery, 2011) and government recommendations that PSIs can support young people's mental health (DoH & DfE, 2017). It is necessary to gain young people's views on the types of PSI that they would perceive as useable, trustworthy, and helpful.

2.6 Conclusion and Definition of Research Problem

Peer support in adolescence.

Intimate peer relationships become more prevalent in adolescence. This intimacy is partly characterised by increased disclosures of personal problems. Adolescents may be reluctant to seek help from professionals for serious personal problems, such as mental illness. They often rely on friends for help with difficult problems. It is unclear whether this is an effective way to address personal problems, particularly mental illness. Adolescents may have negative help-seeking experiences with peers, due to stigma or poor MHL. There is a lack of UK-based research on adolescents' responses to a peer's disclosure of a problem relating to mental illness. There is also a lack of empirical research on why adolescents disclose personal problems primarily to friends.

Adolescents can seek help from peers online or face-to-face; these experiences may be qualitatively different. Previous research has shown that there are some gender differences in seeking and providing peer support. There is a lack of research into the phenomenon of support between adolescent peers for personal problems: for example, the range of personal problems discussed between peers, how often adolescents provide support for friends, and the nature of online disclosures of personal problems. There is also little research from the perspective of the individual to whom the problems are disclosed.

School-based PSIs.

There are several types of school-based interventions to improve pupils' mental health, including PSIs. Whilst PSIs have been defined as young people helping each other in "a planned and structured way" (Coleman et al., 2017, p. 15), the term can be used to include any online or face-to-face intervention relating to peer support, including both formal systems and universal education programmes designed to improve the informal peer support that already exists within adolescent friendships. PSIs may be unpopular with adolescents; there is therefore a need to gain their views on what types of PSI they would consider useable and effective.

2.7 Research Aims

Based on the research problem identified in Section 2.6, the overarching aims of this study were:

- to explore how adolescent peers support one another with personal problems, including mental illness;
- to explore why adolescents might prefer to disclose personal problems to peers;
- to explore adolescents' perceptions of school-based PSIs; and
- to inform the future development and implementation of a PSI which adolescents perceive to be useable and effective.

These aims were achieved by working with adolescents to elicit:

- experiences of supporting peers with personal problems,
- views on why they might choose to disclose a personal problem to a friend,

- perceptions of how they might respond to a peer's disclosure of a personal problem relating to mental illness, and
- perceptions of the effectiveness of existing types of school-based PSIs.

The intended outcome of this study was to gain information on how adolescents support each other with a range of personal problems that might affect their position on the mental health continuum, and a specification of what adolescents would consider an effective and useable school-based PSI.

3. Research Questions and Methodology

3.1 Research Questions (RQs)

This study met the research aims in two phases. The RQs for Phase 1 were:

1.1 What are adolescents' experiences of peers disclosing a personal problem?
   a. How often do they experience peer disclosures?
   b. What personal problems do peers disclose?
   c. How are the disclosures made?

1.2 How do adolescents predict that they would respond to a peer disclosing serious personal problems relating to mental illness?

1.3 How confident do adolescents feel in responding to a peer disclosing serious personal problems relating to mental illness?

1.4 Are there differences in experiences of and responses to peer disclosures according to gender?

The RQs for Phase 2 were:

2.1 What factors do adolescents take into account when considering whether or not to disclose a problem to a friend?

2.2 What are adolescents' views on what makes an effective PSI?

3.2 Research Paradigm

My approach to the research was rooted in pragmatism. The philosophy of pragmatism considers research to be a form of inquiry which involves examining problematic beliefs and resolving them through action (Morgan, 2014). Research is a tool by which to gain the best possible working knowledge to progress towards solving everyday problems: It does not "reveal" truth as a representation of an external reality, but presents truth as action which helps to solve particular problems (Briggs, 2019).

Pragmatism is a methodological approach which challenges the notion of positioning research within a particular epistemology (Briggs, 2019). The primary concern of pragmatism is the difference it makes to acquire knowledge in a certain way and to produce a certain kind of knowledge, rather than assigning

specific approaches to ontological and epistemological “camps” (Morgan, 2014). Within the pragmatist approach, the researcher does not have to choose between a theory-driven or data-driven approach to research methods, but can move between different approaches to theory and data (Morgan, 2007).

According to pragmatism, research is a human experience, based on the researcher’s beliefs and actions. It prompts questions about how decisions are made and the impact of those choices (Morgan, 2014). My decisions as a researcher were guided by the constructivist approach to inquiry. Constructivism considers reality to be a product of subjective experience, and knowledge to be created through social processes (Mustafa, 2011). However, the pragmatist approach challenges the dichotomy between subjectivity and objectivity: It posits that our understanding of the world is limited to our interpretations of our experiences, but that these experiences are constrained by an external reality (Morgan, 2014). In line with this approach, both phases of this study explored adolescents’ experiences and interpretations of peer disclosures and PSIs. Adopting a pragmatist approach gave me freedom to use research methods which best met the aims of the study (Teddlie & Tashakkori, 2009). These were methods traditionally associated with post-positivism and constructivism.

This study used a combination of methodologies. According to Teddlie and Tashakkori (2009), this allows the researcher to answer confirmatory and exploratory questions and to achieve depth and breadth when investigating complex social phenomena. Rather than combining qualitative and quantitative data, as might be inferred from the term *mixed methods*, this study put into sequence two types of design. The data from each phase were analysed separately, and the conclusions were then combined to meet the overall aims. A complementary strengths thesis on paradigm issues was adopted: that qualitative and quantitative data should be kept separate to realise the strength of each paradigmatic position (Teddlie & Tashakkori, 2009).

A combination of confirmatory and exploratory methodologies was deemed appropriate for this study, to gain breadth (Phase 1) and depth (Phase 2) in the investigation of the social phenomenon of support between adolescent peers. The RQs for Phase 1 involved exploration of measurable and generalisable phenomena. A traditionally quantitative research method was therefore adopted, generating categoric data. The confirmatory element of the study investigated:

- whether adolescents experience peer disclosures of personal problems,
- the nature of these disclosures,
- how adolescents predict that they would respond to disclosures of personal problems,
- adolescents' confidence in responding to disclosures of personal problems, and
- whether gender had an effect on adolescents' experiences of and responses to such disclosures.

The RQs for Phase 2 sought the views of young people. This was an exploratory, open-ended study, so a traditionally qualitative research method was adopted, generating context-specific data with an emphasis on meaning and interpretation (Morgan, 2017). Phase 2 explored adolescents' perceptions of why they might prefer to disclose a personal problem to a peer and what would make an effective PSI.

The data from each phase were analysed separately, then combined to form conclusions about the phenomenon in question (Section 7.1).

3.3 Research Tools: Phase 1

Why questionnaires?

In Phase 1, participants completed a self-administered questionnaire eliciting categoric data to answer the confirmatory RQs for Phase 1. The questionnaire (Appendix A) contained mostly multiple-choice questions; open-ended questions were limited, as they are time-consuming to answer and can elicit superficial or ambiguous responses (Oppenheim, 1992). Some open-ended questions were included, to allow for responses which I had not anticipated and to elicit more diverse responses (Reja, Manfreda, Hlebec, & Vehovar, 2003).

Delivering a questionnaire to a large sample achieved breadth in understanding elements of personal disclosures between adolescent peers. Questionnaires do not offer flexibility for participants to describe elements of the studied phenomenon that they consider important (Oppenheim, 1992). However, questionnaires can reach a large number of participants, so more individuals' experiences are taken into account. In a review of children's views on research methods, some young people expressed a preference for questionnaires

because of the perceived fairness of gaining views from a higher number of children (Hill, 2006).

Development of research tools.

The questionnaire was in two parts. Part A contained questions eliciting responses to answer RQ1.1. Part B used vignettes to elicit responses to RQs 1.2 and 1.3. I designed the questionnaire in order to clearly link the questions to the RQs and therefore achieve the aims of the research (Coughlan, Cronin, & Ryan, 2007).

Part A.

Table 1 displays the questionnaire questions that were designed to answer each element of RQ1.1.

Table 1
Links between RQs and Part A of the questionnaire

RQ	Questionnaire [a]
1.1a How often do adolescents experience peer disclosures?	1. How often does a friend talk to you about [problem]?
1.1b What personal problems do adolescent peers disclose?	1. How often does a friend talk to you about [problem]? 2. Think of a problem that was difficult to deal with.
1.1c How are disclosures of problems made between adolescent peers?	3. How do your friends usually come to you with a problem? 5. Have you found out about a problem posted publicly on social media? 4 + 6. Which social media platforms are used?

[a] Questions are paraphrased for brevity. Numbers refer to the question numbers in the questionnaire (Appendix A).

Part A contained questions regarding how often a friend had come to the participant with various named problems. The identified problems were about friendships, family, school, mental health, and physical health. These categories were influenced by research investigating adolescent stressors (Boldero & Fallon, 1995; Byrne & Mazanov, 2002; Seiffge-Krenke, 1995). Questionnaires developed from these studies have been used in recent research on adolescent stress (e.g. Eppelmann et al., 2016). However, this is a fast-moving field. A list of stressors in the Adolescent Stress Questionnaire (Byrne & Mazanov, 2002) was updated just five years later due to the adolescent participants questioning its relevance (Byrne et al., 2007). I felt that existing questionnaires and stressor-lists may not be relevant to the participants of this study; instead I used my experiences of working with adolescents to design this section of the questionnaire. Because this approach was unlikely to produce a comprehensive list of the types of problems discussed by participants, I included an open question for participants to add another problem-type.

Part B.

In Part B, participants were presented with two of a possible three vignettes in which a friend discloses a personal problem relating to mental illness (Appendix B), followed by questions to elicit their response to the disclosure.

Choice of problems in the vignettes.

The problems included in the vignettes were anxiety, depression, and self-harm. These problems were chosen based on the most recent available research into the prevalence of mental health difficulties in children aged 5-16 in the UK (Green, McGinnity, Meltzer, Ford, & Goodman, 2005). The most common disorders were conduct disorder (5.8%), anxiety (3.3%), and depression (0.9%).

Anxiety and depression were included in the current study as I felt that these "emotional disorders" (Green et al., 2005, p. 71) were more likely to be discussed between adolescent peers than conduct disorders, which are characterised by poorly controlled behaviours (American Psychiatric Association [APA], 2013, p. 461). There is a precedent for this in studies using vignettes to assess MHL (Burns & Rapee, 2006; Coles et al., 2016; Marshall & Dunstan, 2013).

Self-harm was also included as a problem relating to mental illness in this study. Self-harm is not included in prevalence data of mental disorders (e.g. Green et al., 2005) because it is a symptom of diagnosable mental health conditions (APA, 2013), rather than a classifiable disorder. Self-harm is a means of expressing distress and seeking relief from "a terrible state of mind" (Rodham, Hawton, & Evans, 2004, p. 82) and is a predictor of suicide (Cooper et al., 2005). Self-harm is also prevalent in the population from which the sample of this study was taken. According to a large-scale study of English adolescents, 6.9% of participants had self-harmed in the past year, and 10.3% had ever self-harmed (Hawton & Rodham, 2006, p. 41). I therefore considered self-harm an important personal problem relating to mental illness. The inclusion of self-harm also allowed meaningful comparison with studies examining adolescent help-seeking behaviours for self-harm (e.g. Evans et al., 2005; Fortune et al., 2008; Reichardt, 2016).

The data for adolescent mental health in the UK available at the time of the questionnaire design were outdated. Updated statistics have since been released (Sadler, Vizard, Ford, Marcheselli, et al., 2018), using slightly different categories of mental illnesses, but still supporting the chosen vignettes.

Content of the vignettes.

The depression vignette was adapted from a vignette in the Friend in Need Questionnaire (Appendix B): a tool to assess MHL (Burns & Rapee, 2006, pp. 236-237). It featured diagnostic criteria for a depressive disorder according to the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM-V), including depressed mood, diminished pleasure in activities, low energy, feelings of worthlessness, and suicidal ideation (APA, 2013, pp. 160-161). I adapted it to:

- be more relevant to a UK context,
- make the language more simple,
- place a stronger emphasis on the character seeking help, and
- position the participant as the character's friend.

I designed the anxiety vignette to include diagnostic criteria for a diagnosable anxiety disorder according to the DSM-V, including excessive and uncontrollable worry and sleep disturbance (APA, 2013, p. 222). The self-harm vignette met

Hawton and Rodham's (2006) definition of deliberate self-harm: "an act with a non-fatal outcome in which an individual deliberately . . . initiates behaviour (such as self-cutting, hanging) that they intend to cause self-harm" (p. 194). I used my professional experience to set the problem disclosures in contexts which would be familiar to the participants, including the use of social media. They were piloted with adolescents, who agreed that the vignettes were realistic.

Two of the three possible vignettes were included in each questionnaire, to reduce the length. When young people participate in a questionnaire that they perceive as boring, they may give subversive responses, affecting the reliability of the data (Hill, 2006). The order of the vignettes was counterbalanced. The gender of the characters were also counterbalanced, as previous research suggested that the gender of the discloser and disclosee may affect help-seeking and help-giving behaviours (e.g. Mason et al., 2015; Yap et al., 2011). The counterbalancing produced 24 questionnaires, which were distributed randomly to participants. Responses were not analysed in relation to the interaction between the gender of participants and the gender of the vignette-characters, as the numbers of male and female respondents to each gender of vignette-character were too small for meaningful analysis.

Questions following each vignette.

Table 2 displays the questionnaire questions that were designed to answer RQs 1.2 and 1.3.

Table 2
Links between RQs and Part B of the questionnaire

RQ	Questionnaire [a]
1.2 How do adolescents predict that they would respond to a peer disclosing serious personal problems relating to mental illness?	1 + 2. What would you think/say when you heard what -- said? 4. Would you do something about –'s problem? If yes, what?
1.3 How confident do adolescents feel in responding to a peer disclosing serious personal problems relating to mental illness?	3. How confident do you feel that you said the right thing to --? 5. How confident do you feel that you have done the right thing?

[a] Questions are paraphrased for brevity. Numbers refer to the question numbers in the questionnaire.

Existing research on adolescents' responses to a peer exhibiting signs of mental illness usually includes measures of stigma or actions taken (e.g. Yap et al., 2011). In this study, a broader view of *response* was taken. Through discussion with research supervisors, it was agreed that a response to a peer's disclosure of a mental illness would comprise thought, speech, and action, and that these elements could be in conflict. The questions following each vignette were divided into these three categories.

Open-ended and closed-ended questions were used. Options for the thought and verbal responses were in a multiple-choice format. This was to avoid methodological limitations identified in previous similar studies, such as brief, uncodable responses (Mason et al., 2015). An open-ended "Other" option was included, in case participants felt that the multiple-choice options were not representative of their response (Oppenheim, 1992). The multiple-choice options were influenced by Ross et al.'s (2012) Delphi study, which developed key MHFA messages for adolescents who suspected that a friend was suffering from a mental illness.

An open-ended question was used for the action response: I felt that actions would be more concrete than the thought and verbal responses, and may therefore elicit more detailed answers. I hoped that participants would give an adequate response to this question because they would have first agreed that they would take action and may therefore have already decided what action to take.

Pilot of research tools.

A pilot was conducted at an inner-city secondary school in the South-West of England. Letters were sent home to one Year 9 maths class. The questionnaire was delivered to the six adolescents (three male and three female) whose parents had returned the consent form. Informed assent was gained verbally by the participants. Participants were informed that their role in the research was to test the research tools and that participation was voluntary.

Each half of the group completed one version of the questionnaire. The versions involved different wording of Question 1. One version included the depression and anxiety vignettes, and one included the self-harm vignette and a vignette which was not included in the final study (due to counterbalancing resulting in an unruly number of questionnaire-versions). The participants took ten minutes to complete the questionnaire. They were a high academic ability group, so I left more time for participants of the final study to complete the questions.

I asked the participants to inform me of anything they had found confusing, distressing, or irrelevant. They had no negative comments and stated that they had found the vignettes believable. They had found it challenging to answer the questions following the vignettes, but only because they were unsure how to react to the vignette in question, rather than the questions themselves being unclear. One participant reported that she felt she was being asked to “tell tales” on her friends. Young people participating in research questionnaires can feel uncomfortable when asked questions which they perceive as intrusive (Hill, 2006). I therefore noted the importance of emphasising the confidentiality of participants’ responses and the voluntary nature of participation. One minor change was made to an instruction in the questionnaire based on the participants’ feedback.

3.4 Research Tools: Phase 2

Why focus groups?

Phase 2 was designed to gain detailed insight into the participants' views. Focus groups were used to meet this aim. This research method elicited depth and detail relating to the phenomenon of interest (Morgan, 2017). The interactive nature of focus groups was consistent with the pragmatist position that knowledge lies in the interactions between people (Briggs, 2019). A semi-structured interview schedule was used (Appendix C) to gain data relevant to the RQs, whilst also allowing participants to expand on issues that were important to them (Denscombe, 2017).

This study was designed to address the under-representation of young people's voices in existing research about school-based support (Atkinson et al., 2019). Interviews and focus groups allow young people to express their own interpretations and thoughts, rather than being interpreted and defined by the views of adults (Eder & Fingerson, 2001). Focus groups reduce the power of the researcher and are less intimidating for participants than individual interviews (Braun & Clarke, 2013; Hill, 2006). I hoped that this research method would allow the participants to feel confident in expressing their views.

Kitzinger (1995) distinguished between group interviews (a way to collect data from several people at the same time) and focus groups, in which group interaction is integral to the method. Focus groups allow participants to interact by agreeing or disagreeing with one another, producing naturalistic data (Braun & Clarke, 2013). This was particularly pertinent to this study, which examined peer relationships. It was hoped that the participants' experience of discussing the topic with peers would elicit further reflections on the subject matter of the focus group. Students of mixed gender and academic abilities participated in each focus group, to maximise the exploration of diverse opinions within the group (Kitzinger, 1995).

Development of research tools.

I designed the semi-structured schedule to answer RQs 2.1 and 2.2. The opening questions were designed to answer RQ2.1. There were then introductory questions to RQ2.2, to help clarify the topic of discussion and to encourage

participants to discuss PSIs with which they were already familiar. For RQ2.2, participants' views of existing types of PSI were explored, thereby eliciting their views on what elements of PSIs they felt would be successful.

Participants were presented with three types of PSI. This included two types of formal PSI, in which adults set up a system within which peers support one another in a structured way. This organised system can take place face-to-face (referred to as *organised PSIs*) or online (referred to as *online PSIs*). The third PSI-type is *universal PSIs*, in which all young people are prepared by adults to improve the support they provide informally to peers.

I gave a description and example of each PSI-type and used cartoon-style drawings to provide visual supports (Appendix D), as recommended by Vaughn, Schumm, and Sinagub (1996). The participants were invited to comment on the PSI-types, including advantages and disadvantages of each one. Vaughn et al. (1996) recommended that focus groups with young people should involve something to keep participants active; I included an activity in which participants marked where they felt each PSI-type belonged on a matrix of helpfulness and usability.

Pilot of research tools.

The focus group schedule was piloted on the same six participants who piloted the Phase 1 questionnaire. They were presented with four PSI-types: organised PSIs (face-to-face and online) and universal PSIs (face-to-face and online). The pilot lasted an hour. It was likely some schools would allow less time for the research, so I omitted the online universal PSI from the study, as this was the PSI-type which elicited the least novel data from the pilot participants.

Conducting a pilot focus group allowed me to practise eliciting views from all participants, regardless of their confidence within the group. It also confirmed my hope that the visual supports would add focus and clarity to the discussion. During the pilot, I decided to ask participants to complete the matrix activity after discussion of each PSI, rather than at the end of the focus group. This allowed the participants to take short breaks throughout the focus group.

After the pilot focus group, the participants gave positive feedback: They felt that the group was an appropriate size and the questions were thought-provoking but

easy to understand. They commented that the focus group would only work well if all members of the group discussed the topic maturely.

After the focus group pilot, I made the following changes to the interview schedule:

- removed the online universal PSI from the PSI-types presented to participants;
- included the option to ask about the participants' experiences of PSIs at primary school, if they were not able to think of examples at secondary school; and
- carried out the matrix activity after discussion of each intervention, rather than at the end of the focus group.

3.5 Sampling and Procedure

Recruitment: participating schools.

Information about the study was shared via email with all mainstream state-funded secondary schools in a local authority (LA) located in a "suburban manufacturing area" of the West Midlands (Social Mobility Commission, 2017, p. 12), in which I worked as a trainee educational psychologist (EP).

Schools were contacted via the Special Educational Needs Coordinator (SENCo). Contact details for SENCos were sought through the EP Service. Reminder emails were sent several weeks after the initial email. I explained the research process in person or on the phone to the three schools whose SENCo (or another school-link) expressed interest at this stage. All of these schools were included in the study. Signed consent was gained from a member of the senior leadership team at each participating school (Appendix E).

Table 3 displays data about participating schools. All schools were mainstream co-educational secondary academies.

Table 3
Demographic data for participating schools

Descriptor	School A	School B	School C	England average
Ofsted status [a]	Requires Improvement	Outstanding	Good	N/A
Pupils with an Education, Health and Care Plan [a]	2%	2%	2%	4%
Pupils whose first language is not English [a]	5%	1%	24%	16%
Pupils eligible for free school meals in past 6 years [a]	59%	26%	62%	29%
Percentage of white British people in ward where school is located (2011 census)	89% [b]	86% [b]	81% [b]	86% [c]

[a] Retrieved from https://www.compare-school-performance.service.gov.uk/find-a-school-in-england [Accessed 16 May 2019]
[b] Website omitted for anonymity.
[c] Retrieved from https://www.ethnicity-facts-figures.service.gov.uk/british-population/national-and-regional-populations/population-of-england-and-wales/latest

Phase 1: sampling.

In each school, up to 150 Year 9 pupils (aged 13-14) were invited to complete the questionnaire. This year group was selected because pupils have reached adolescence and are unlikely to be working towards national exams, which may have made schools reluctant to release students from lessons. If there were more than 150 Year 9s at the school, the school-link selected which classes would participate, based on convenience factors such as timetabling. Demographic data for participants at each school are displayed in Section 4.1.

Phase 1: data collection.

Parent letters were distributed by the school one week before the date of the research (Appendix F). Letters were returned if parents did not want their child to participate. I met all participating pupils to give information about the study, including the voluntary nature of participation, confidentiality, and the purpose of

the study. Participants signed their assent before completing the questionnaire (Appendix G). Details of ethical procedures are outlined in Section 3.8.

To complete the questionnaires, participants either returned to their classrooms with their class teachers (School 1) or remained in the hall with me and supervising staff (Schools 2 and 3). I collected the completed questionnaires and signed assent forms.

Phase 2: sampling.

All students in Year 9 were eligible to take part in the focus groups. Students were recruited by the school-link according to my request for an even gender-balance and a range of academic abilities in each group. I aimed to conduct two focus groups of 6 students at each school. This was consistent with Terry, Hayfield, Clarke, and Braun's (2017) recommendation for a professional doctorate project sample size for a qualitative study using focus groups. School-links were responsible for arranging the recruitment, timing, and location of focus groups. The number of participants in each focus group varied according to whether the participants had brought in their parental permission slip and whether they chose to participate once I had reasserted their voluntary participation.

Table 4 summarises the demographics of each focus group. All participants were in Year 9. In order to protect participants' anonymity, the collection of demographic information from participants was limited to school, gender, and year group.

Table 4
Demographic data for focus group participants

School	Female	Male
School 1	2	3
	2	2
School 2	3	3
	3	1
School 3	3	4
	4	2
Total	17	15

Phase 2: data collection.

Letters were sent to parents of the selected pupils one week before the day of the research (Appendix H). Parental permission slips had to be returned for the pupils to participate. If participants could not provide their permission slip, they were politely asked to return to their lesson. Participants signed their assent and a confidentiality agreement (Appendix I). They were reminded verbally and in writing that they could leave at any time. Some participants decided to return to their lesson. To protect their right to privacy, these participants were not required to explain this decision. Focus groups lasted the length of one lesson: usually 45-60 minutes. They were recorded using a digital recorder, once all participants had given permission. In Schools 1 and 3, the focus groups were conducted after participants had completed the Phase 1 questionnaire.

Due to the group dynamics of focus groups, the views of some participants can be promoted and those of others can be suppressed (Albrecht, Johnson, & Walther, 1993). This is a particular concern among adolescents, who often value peer relationships highly (Nurmi, 2004). I used my experience of working with adolescents in educational settings to encourage all members of the focus groups to contribute their opinions. The written matrix activity also facilitated less confident participants in expressing their opinions.

3.6 Data Analysis: Phase 1

Closed questions.

Numerical data from Phase 1 was input into IBM SPSS Statistics Version 24 software. Descriptive statistics were generated to answer RQs 1.1, 1.2, and 1.3. Microsoft Excel Version 16.23 software was used to generate graphs.

To answer RQ1.4, male and female responses were analysed separately, to allow for comparison. Inferential statistics were used to establish whether there were significant gender differences for specific questions. Missing data and *no-gender* participants (those who left the gender question blank or provided an answer other than male or female) were excluded from these tests.

Open questions: content analysis.

Data from open questions were analysed using basic content analysis: a structured research approach which requires the researcher to report how data were collected, coded, and analysed (Drisko & Maschi, 2015). It utilises traditionally qualitative (coding) and quantitative (descriptive statistics) techniques and was therefore consistent with the pragmatist paradigm of this study.

Data were coded inductively: The codes were developed and adapted throughout the analysis of the data set. Basic content analysis usually involves coding manifest data (Drisko & Maschi, 2015); however, some data in this study were more suited to methods of content analysis in which units are distinguished by themes. This approach can produce rich findings, but it can be more difficult to achieve reliability (Krippendorff, 2004). In keeping with the pragmatist paradigm of the study, some latent content was interpreted, where there was ambiguity. To improve the dependability of the study, my reflections on how decisions were made at each stage of the content analysis are provided in Section 7.2.

Findings were summarised where appropriate, with relevant codes grouped together. This process is outlined in the next section. Full frequency tables of all codes can be found in Appendix J.

Part A.

The following process was used to analyse participants' answers regarding "Other" types of problem discussed with friends and problems that were difficult to deal with.

Questionnaire responses were recorded. Similar answers were grouped at this stage, creating an early-stage frequency count. Notes were kept to ensure consistency in grouping across the data set (Appendix K). I read through the data and developed a set of working codes. I reviewed the data and codes; no revisions were made. I conducted a simple frequency count of each code and generated descriptive statistics.

To analyse participants' answers regarding social media platforms used to share problems, a simple frequency count was conducted of each social media platform. Of the 23 different answers, only five platforms were listed more than

five times. These platforms were listed separately. For the remaining 18 answers, I conducted a brief internet search on each platform. One platform was discarded as it could not be identified. The remaining answers were grouped where possible according to Osatuyi's (2013) widely used categories. Answers which did not fit into these categories were grouped according to my knowledge of the platforms. Descriptive statistics were generated.

To analyse participants' answers regarding social media platforms used to share problems publicly, I conducted a simple frequency count of each platform. Of the 10 platforms given, only three were listed more than twice. These three platforms were listed separately. The remaining answers were grouped into a category entitled "Other." Descriptive statistics were generated.

Part B.

Content analysis was also conducted on answers to the open questions in Part B of the questionnaire. These questions asked what the participant would think, say, and do in response to the vignette-character's disclosure.

The answers to these questions were combined, as participants often gave responses that did not necessarily correspond with each specific question. I felt that the answers to all of the open questions constituted the participant's response to the vignette, regardless of which question the answer was written under. As a result, the descriptive statistics refer to the frequency of the answers given, rather than the frequency of participants who gave the answer. It is possible but unlikely that one answer could have been recorded up to three times by one participant, if the participant had written the same answer in all three boxes. I felt that the benefits of combining the responses (and therefore not discarding data which was irrelevant to each specific question) outweighed the risk of recording some responses more than once.

All questionnaire responses were recorded. Similar answers were grouped at this stage. Notes were kept to ensure consistency in grouping across the data set throughout the process (Appendix K). I then engaged in inductive coding: developing a set of working codes while reading through the data set. Some codes were changed throughout the coding process (e.g. codes were merged or divided): In this circumstance, I returned to previously coded data to make the

relevant changes. I conducted a simple frequency count of each code and generated descriptive statistics.

3.7 Data Analysis: Phase 2

I transcribed recordings of the focus groups, using the online software Transcribe (https://transcribe.wreally.com). Transcripts were then checked against the recordings for accuracy. Due to the difficulty of identifying individual speakers on the recordings, participants were described on the transcripts by gender. The purpose was to help clarify different speakers on the transcripts, not to analyse male and female answers separately.

Data were analysed using thematic analysis (Braun & Clarke, 2006). The study sought the views and experiences of young people. The data analysis therefore had an experiential orientation, grounded on the assumption that language reflects reality (Terry et al., 2017). I adopted an inductive approach to thematic analysis: a data-led approach in which coding is a flexible process based on detailed and repeated engagement with the data (Terry et al., 2017). This form of analysis was consistent with the exploratory nature of Phase 2 of the study, which engaged with meaning and interpretation. All data relevant to the RQs were coded, including data-derived codes (summaries of explicit content in the data) and researcher-derived codes (my interpretations of implicit meanings within the data; Braun & Clarke, 2013). The analysis was an iterative process, with review and changes of themes and subthemes an integral part of the analytical process.

Appendix L outlines each stage of the thematic analysis process. To summarise, initial codes were made based on the RQs and focus group questions (Appendix M). Codes were then organised into overarching themes (Appendix N), which I organised into tables according to RQ (Appendix O). I noted that similar themes recurred across analysis of each PSI and decided to combine themes and subthemes across the three PSIs (Appendix P). I made thematic maps for each RQ (Appendix Q), then reviewed and named the themes and subthemes. Reflections on my role in the process of analysis are provided in Section 7.2.

As well as producing audio-recorded data, participants marked each PSI-type on a matrix. I converted participants' responses on the graph into numerical data,

allowing the responses to be plotted as a scatter graph in Microsoft Excel Version 16.23. This allowed direct comparison of the participants' views on each PSI.

3.8 Ethical Considerations

Ethical approval was gained from the University of Exeter Graduate School of Education Ethics Committee (Appendix R). The research adhered to the British Psychological Society (BPS) Code of Ethics and Conduct (Ethics Committee of BPS, 2018) and Code of Human Research Ethics (BPS, 2014). See Appendix S for further details of actions taken to address ethical issues.

Phase 1.

An information and consent form was sent to parents one week prior to the administration of the questionnaire (Appendix F). Passive consent was gained from parents. I met with all participants before they completed the questionnaire and explained the purpose of the study and the voluntary nature of participation. This was also written on the front page of the questionnaire (Appendix A). Participants signed their assent before completing the questionnaire. Before the implementation of General Data Protection Regulation (GDPR), School 1 participants signed their assent on the front page of the questionnaire; their answers were treated confidentially. GDPR required that the questionnaires were rendered anonymous; participants at Schools 2 and 3 signed assent on a separate piece of paper (Appendix G). All data was reported anonymously. The content of the questionnaire could have evoked emotional distress. Measures taken to address this risk are outlined in Appendix S.

Phase 2.

Active parental consent was gained by letter one week before the focus groups (Appendix H). At the start of each focus group, participants were informed verbally of the voluntary nature of their participation and the purpose of the study. They were also informed of their right to withdraw at any point during the focus group, and up to one week after it. Participants signed their assent and a confidentiality agreement at the start of the focus group (Appendix I). They were

informed that I would pass any safeguarding concerns onto a member of school staff. Data was reported anonymously.

4. Phase 1 Findings

This section details the results of Phase 1. The analysis of the findings is presented in Section 5. The results are presented according to RQ (see Table 5). In answer to RQ1.4, gender differences are reported throughout.

Throughout the findings, “participants” refers to the total number of people who took part in the study. “Respondents” refers to the number of participants who gave a response to a specific question. All percentages are given to two decimal places.

Table 5
Sections containing Phase 1 findings according to RQ

Section	Title	RQ
4.1	Demographic data	-
4.2	Types of problem disclosed by peers	1.1a
	Problems in questionnaire	1.1b
	‘Other’ problems	
	Difficult problems	
4.3	How disclosures are made	1.1c
	Technology or face-to-face?	
	Social media	
	Social media: public disclosures	
4.4	Responses to a serious problem	1.2
	What would you think?	
	What would you say?	
	Would you do anything?	
	Open responses	
4.5	Confidence in responding to serious problem	1.3
	Saying the right thing	
	Doing the right thing	

4.1 Demographic Data

Participants were in Year 9 and therefore aged 13-14. Further information about the sample can be found in Section 3.5. Table 6 displays the number of participants who completed the questionnaire at each school. Percentages of male, female, and no-gender participants at each school are given in

parentheses. The “Total” row shows the number of participants across all schools, by gender. The “Total” column shows the number of participants from each school.

Table 6
Demographic data for questionnaire participants

School	Male (%)	Female (%)	No-gen (%)	Total
School 1	74 (49.01)	70 (46.36)	7 (4.64)	151
School 2	43 (39.45)	53 (48.62)	13 (11.93)	109
School 3	60 (46.15)	59 (45.38)	11 (8.46)	130
Total	177 (45.38)	182 (46.67)	31 (7.95)	390

The term *no-gender* (or *no-gen*) is used to describe those who did not give an answer to this question (*n* = 29) and the few participants who gave a response other than male or female (*n* = 2). These responses were “other” and “werewolf.”

Where there were fewer than 15 no-gender respondents to a question, these responses were omitted from presentation of results. No-gender responses were also excluded from presentation of the Open Question results (Section 4.4): There were very low no-gender response rates for each code due to the wide range of responses. Tables J1-J17 display frequencies including all three gender-groups for these questions.

All tables display the frequency of responses and the percentage of respondents who gave each answer. Table 8 is the only exception, as the number of respondents in each category were very similar; percentages were excluded to allow the results to be presented in one clear table. Figures display the percentage of respondents who gave each answer, with the exception of those displaying content analysis of the open responses by gender (Figures 19-21, 23-25, and 27-29). This was to communicate the low frequency of responses for each code group.

4.2 Types of Problem Disclosed by Peers

Problems provided in the questionnaire.

Participants were asked how often a friend talks to them about specific problems. They selected from five multiple-choice answers. These answers were grouped

and renamed, as displayed in Table 7. This was to support clarity and concision in the display of the results.

Table 7
Problem frequencies in questionnaire: new categories for analysis

Questionnaire	New category
Most days	Often
Once a week Once a month	Sometimes
Once a year	Rarely

Table 8 displays the frequency of answers for each problem type, by gender. "Total" rows display the number of respondents who gave each answer. The "Total" column displays the number of respondents to each question according to gender.

Table 8
How often participants discuss problems with friends

Problem type	Gender	Often	Sometimes	Rarely	Don't know	Total
School	Male	76	56	20	23	175
	Female	89	59	12	19	179
	No-gen	15	3	6	4	28
	Total	180	118	38	46	382
Friend or group of friends	Male	41	56	40	37	174
	Female	82	65	9	25	181
	No-gen	11	7	7	4	29
	Total	134	128	56	66	384
Other	Male	29	36	37	41	143
	Female	48	38	16	41	143
	No-gen	9	4	5	4	22
	Total	86	78	58	86	308
Family	Male	13	49	71	42	175
	Female	39	80	25	37	181
	No-gen	5	10	5	9	29
	Total	57	139	101	9	385
Mental health	Male	12	24	108	32	176
	Female	35	50	64	33	182
	No-gen	5	6	12	5	28
	Total	52	80	184	70	386
Physical health	Male	12	38	89	37	176
	Female	12	58	69	41	180
	No-gen	4	9	12	3	28
	Total	28	105	170	81	384

Figure 1

Problem disclosures often received by males and females

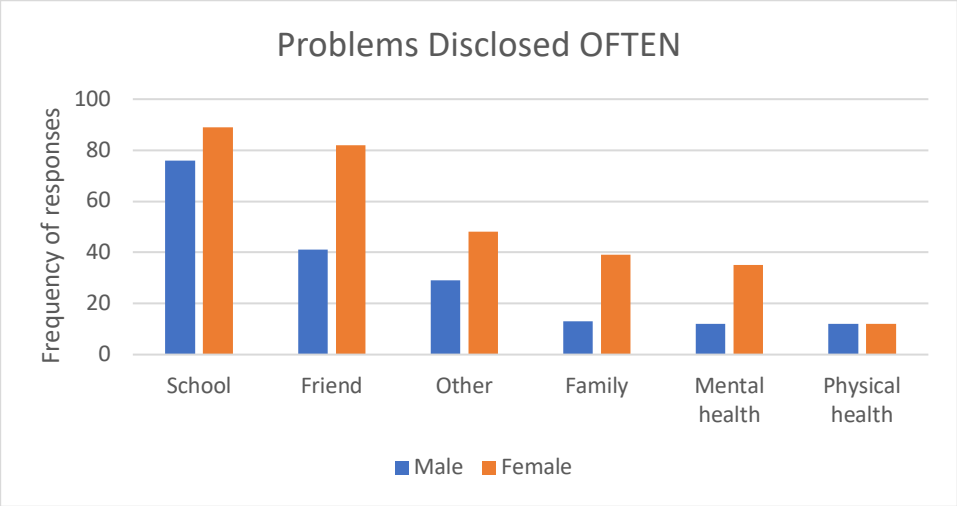


Figure 2

Problem disclosures sometimes received by males and females

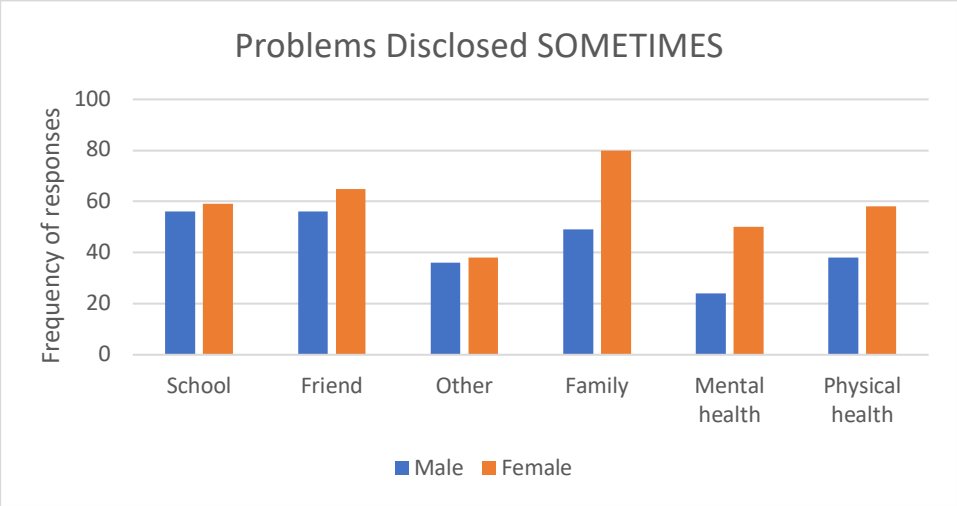
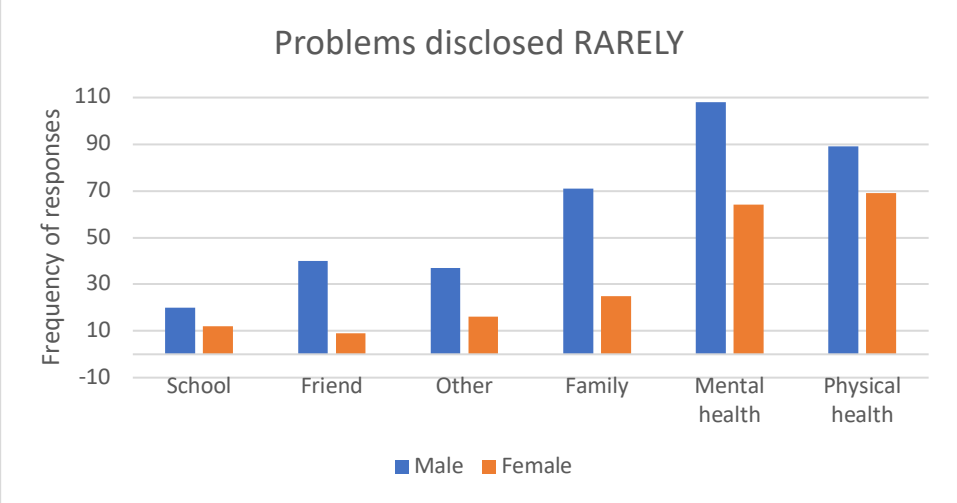


Figure 3

Problem disclosures rarely received by males and females



Figures 1-3 show how often male and female participants receive disclosures from a friend about particular problems. The results show that for both genders, school and friends were the most frequently discussed problems. Mental and physical health were the least frequently discussed problems.

Chi-square tests of independence were performed to examine whether there were significant differences between males and females in how frequently they discussed each problem with a friend (Table 9). There were significant relationships between gender and the frequency of discussions about friendships, family, mental health, and other problems, with females reporting more frequent discussions of these topics than males.

Table 9
Frequency of discussions and gender: significance tests

Problem discussed	Chi-square test of independence	Significance
Friendships	X^2 (3, N = 355) = 36.147, *p* = .000	Yes
Family	X^2 (3, N = 356) = 42.719, *p* = .000	Yes
Mental health	X^2 (3, N = 358) = 31.570, *p* = .000	Yes
'Other'	X^2 (3, N = 286) = 13.063, *p* = .005	Yes
School	X^2 (3, N = 354) = 3.439, *p* = .329	No
Physical health	X^2 (3, N = 356) = 6.859, *p* = .077	No

"Other" problems.

Participants were given an open-ended question to state a problem-type not given in previous questions. Each respondent gave one answer to this question. Responses were analysed using content analysis (Section 3.6). Table 10 displays the six most common answers. It displays the frequencies and the percentage of male (*n* = 52) and female (*n* = 84) respondents who gave each response. No-gender responses (*n* = 11) were excluded and are not included in the "Total" column. Table J1 displays all responses. The response rate to this question was fairly low and the results should therefore be interpreted cautiously.

Table 10
Other problem-types disclosed by peers

Problem	Male (%)	Female (%)	Total (%)
Romantic relationships relating to boyfriend or girlfriend	19 (36.54)	20 (23.81)	39 (28.68)
School stress or problems, including homework	8 (15.38)	7 (8.33)	15 (11.03)
Friendships, including problems with "other people" or relating to popularity	4 (7.69)	10 (11.90)	14 (10.29)
Bullying	4 (7.69)	7 (8.33)	11 (8.09)
Depression, self-harm, or feeling stressed or upset	2 (3.85)	8 (9.52)	10 (7.35)
Anxiety, worry or lacking confidence	0 (0)	9 (10.71)	9 (6.62)

Figure 4
Other problem-types disclosed by peers

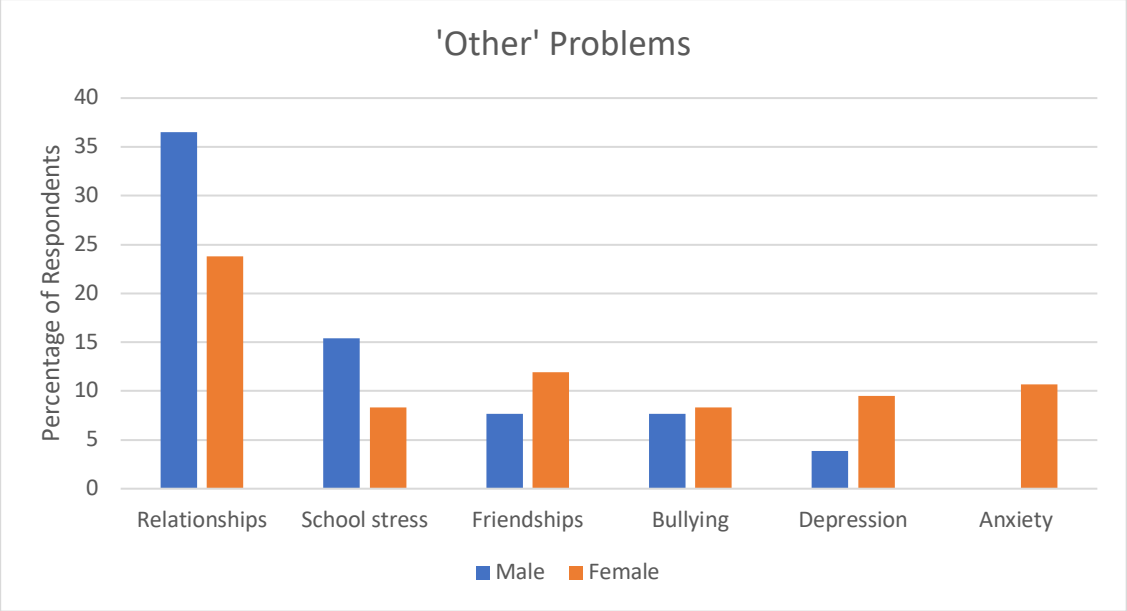


Figure 4 displays the percentage of male and female respondents who listed each response when given the option to provide another problem-type. It shows the six most common answers. Some of these answers were covered by the multiple-choice options (school, friendships, and mental health). The most common unique response was relationships, followed by bullying. More females

than males provided an answer to this question, so most of the six most common responses were listed by more females than males, with the exception of school stress. A greater proportion of male than female respondents listed relationships as a problem that they discuss with friends.

Difficult problems.

Participants were asked to think of a time when a friend came to them with a problem that they found difficult to deal with. Responses were analysed using basic content analysis.

Participants could give more than one response: There were 92 responses given by 87 male respondents, 144 responses given by 132 female respondents, and 8 responses given by 8 no-gender respondents. Table 11 displays the six most common responses: that is, the responses which were most commonly given by participants. It shows the frequency of responses and the percentage of respondents who gave each response, by gender. No-gender participants (n = 8) were excluded and are not included in the “Total” column. Table J2 displays all responses.

Table 11

Problems which are difficult to help a peer with: most common responses

Code	Male (%)	Female (%)	Total (%)
Family	23 (26.44)	43 (32.58)	66 (30.14)
Depression, self-harm, or suicidal thoughts	13 (14.94)	31 (23.48)	44 (20.09)
Relationships	11 (12.64)	18 (13.64)	29 (13.24)
Friendships	8 (9.20)	20 (15.15)	28 (12.79)
Bereavement or serious illness	8 (9.20)	12 (9.09)	20 (9.13)
Bullying	8 (9.20)	2 (1.52)	10 (4.57)

Note. Percentages in parentheses show the percentage of male or female respondents who gave each response, i.e. 26.44% of male respondents (*n* = 87) and 32.58% of female respondents (*n* = 132) listed an answer relating to "family".

Figure 5

Problems which are difficult to help a peer with

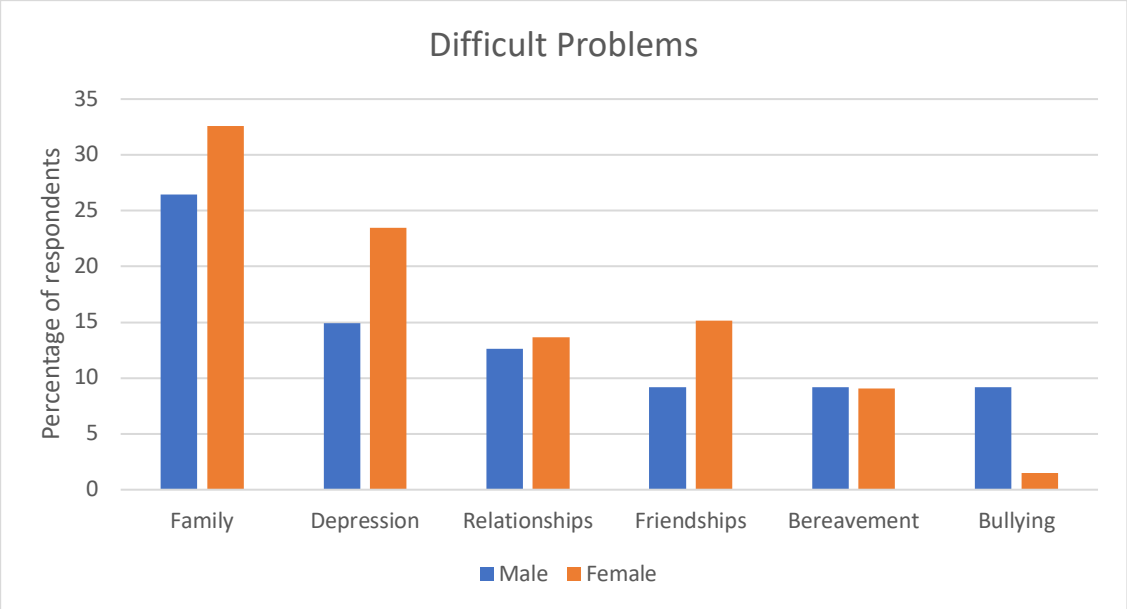


Figure 5 displays the six most common responses to the question asking what kinds of problem participants found difficult to support a friend with. It shows the percentage of male and female respondents who gave each answer. The response given by the highest proportion of respondents was problems relating to the friend's family (30%), followed by mental health difficulties including depression, self-harm, and suicidal thoughts (20%). More females than males gave a response to this question. However, Figure 5 shows that a higher proportion of female than male respondents found problems relating to family, depression, relationships, and friendships difficult to support a friend with. A higher proportion of males than females reported that they had struggled to help a friend with bullying. Similar proportions of males and females had struggled to support a friend with family bereavement or serious illness.

4.3 How Disclosures Are Made

Technology or face-to-face?

Participants were asked how friends usually share problems with them. Table 12 shows the frequency of responses and the percentage of male (*n* = 170), female (*n* = 178), and no-gender (*n* = 28) respondents who gave each response. Questionnaire answers "Almost always" and "Usually" were combined into a new category entitled "Mostly."

Table 12
How participants' friends share problems: technology or face-to-face

Response	Male (%)	Female (%)	No-gen (%)	Total (%)
Mostly face-to-face	62 (36.47)	67 (37.64)	11 (39.29)	140 (37.23)
Equally technology and face-to-face	55 (32.35)	89 (50.00)	6 (21.43)	150 (39.89)
Mostly technology	30 (17.65)	17 (9.55)	4 (14.29)	51 (13.56)
I don't know	23 (13.53)	5 (2.81)	7 (25.00)	35 (9.31)

Figure 6

How participants' friends share problems: technology or face-to-face

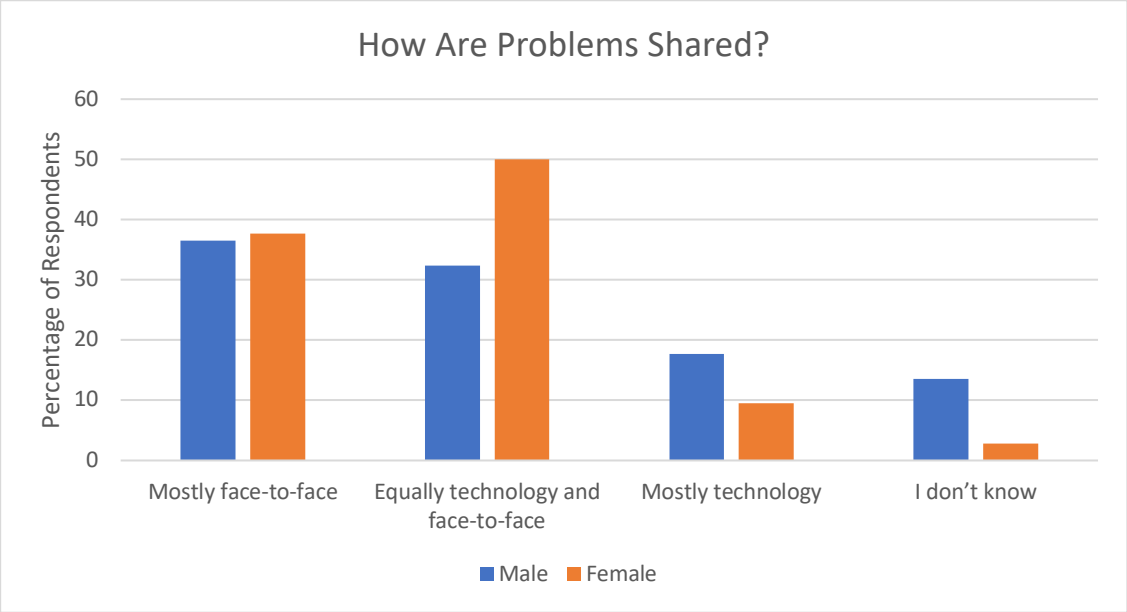


Figure 6 shows how male and female participants' friends usually share problems with them. It shows that a higher proportion of male than female respondents were likely to have friends sharing problems using mostly technology (18% and 10% respectively). More female than male participants' friends were equally likely to share problems using technology and face-to-face (50% and 32% respectively).

A chi-square test of independence was performed to examine the relationship between gender and how problems are reportedly shared between friends. The relationship between these variables was significant, X^2 (3, N = 348) = 23.217, *p* = .000. The descriptive data suggests that overall, females were more likely than males to receive disclosures about personal problems from friends face-to-face.

Social media.

Participants were asked which social media platforms their friends used to share problems. They were asked to give a response if a friend had shared a problem with them on social media. The implication is that participants who did not answer had not received a disclosure of a friend's problem on social media; the actual number may be higher as some participants may have neglected to answer the question. The number of respondents and the percentage of total participants who gave a response are shown in Table 13. It shows that around three quarters

of the participants (with a higher proportion of females than males) had experienced a friend disclosing a personal problem on social media.

Table 13
Participants whose friend had shared a problem on social media

Gender	Respondents [a]	% [b]
Male	126	71.19
Female	158	86.81
No-gender	19	61.29
Total	303	77.69

[a] Frequency of respondents to the question.
[b] Percentage of total participants.

Participants were asked on which social media platform(s) they had received a disclosure of a problem from a friend. Responses were analysed using content analysis and divided into categories as displayed in Table 14. Section 3.6 outlines this process in further detail.

Table 14
Categories of social media platforms used to share problems

Category	Response
Social networking platforms	Amino
	Google Hangouts
Micro-blogging	Tumblr
	Twitter
Media-sharing platforms	Tik-tok
	YouTube
	Discord
Gaming	Fortnite
	Game
	Playstation or PS4
	Roblox
Private calls or messages	Facetime
	Message
	Text
	Phone
	Skype
Dating apps	Tinder

Participants could give more than one response: There were 176 responses given by 126 male respondents, 231 responses given by 158 female respondents, and 35 responses given by 19 no-gender respondents. Table 15 displays the six most common responses: that is, the responses which were most commonly given by participants. It shows the frequency of responses and the percentage of respondents who gave each response, by gender. Table J3 displays all responses.

Table 15
Social media platforms used to share problems: most common responses

Response	Male (%)	Female (%)	No-gen (%)	Total (%)
Snapchat	67 (53.17)	116 (73.42)	11 (57.89)	194 (64.03)
Instagram	43 (34.13)	63 (39.87)	14 (73.68)	120 (39.60)
Facebook	23 (18.25)	18 (11.39)	4 (21.05)	45 (14.85)
Messenger	20 (15.87)	10 (6.33)	0 (0)	30 (9.90)
WhatsApp	7 (5.56)	17 (10.76)	0 (0)	24 (7.92)
Gaming	9 (7.14)	0 (0)	3 (15.79)	12 (3.96)

Note. Percentages in parentheses show the percentage of male, female, or no-gender respondents who gave each response, i.e. 53.17% of male respondents (n = 126) and 73.42% of female respondents (n = 158) listed “Snapchat” as one of their answers.

Figure 7

Social media platforms used to share problems

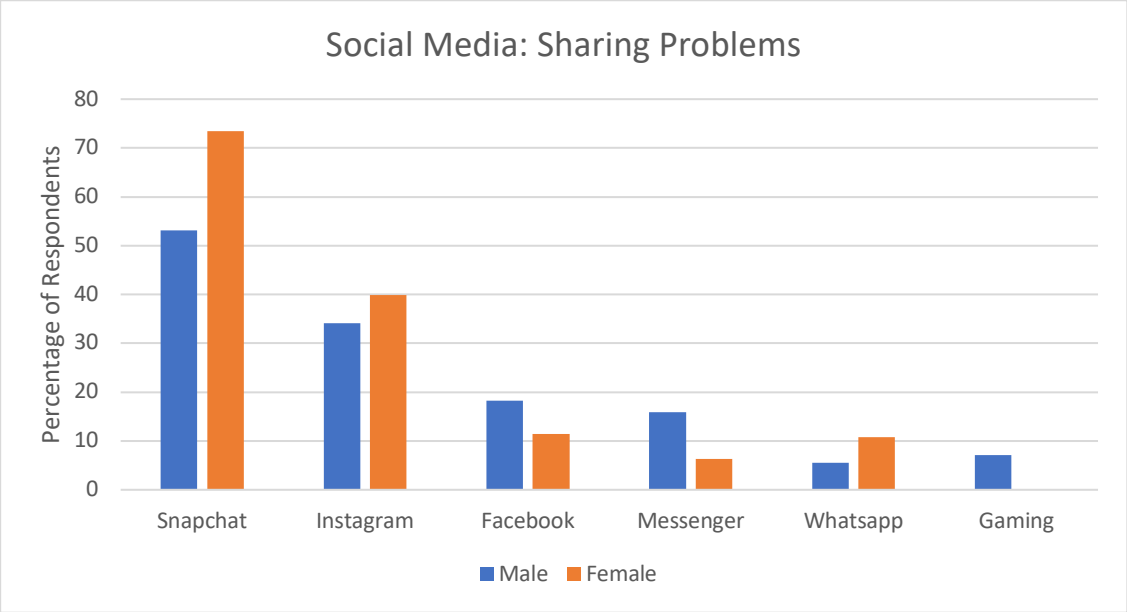


Figure 7 displays the six most common social media websites on which male and female participants had experienced a disclosure of a problem from a friend. It shows that Snapchat and Instagram were the most common answers. A higher proportion of females than males listed these sites, whereas a higher proportion of males than females had received disclosures on Facebook and Messenger. No females had experienced a disclosure through gaming, but this was the fifth most common response for males.

Social media: public.

Participants were then asked if they had ever found out about a friend's problem after the friend had posted something publicly (or to all their friends) on social media, for example in a status update, picture, or video that other people can see. Table 16 displays the frequencies of each response and the percentage of male (*n* = 170), female (*n* = 181), and no-gender (*n* = 27) respondents who gave each response.

Table 16

Respondents whose friend had shared a problem publicly on social media

Response	Male (%)	Female (%)	No-gen (%)	Total (%)
Yes	67 (39.41)	107 (59.12)	12 (44.44)	186 (49.21)
No	103 (60.59)	74 (40.88)	15 (55.55)	192 (50.79)

Figure 8

Respondents whose friend had shared a problem publicly on social media

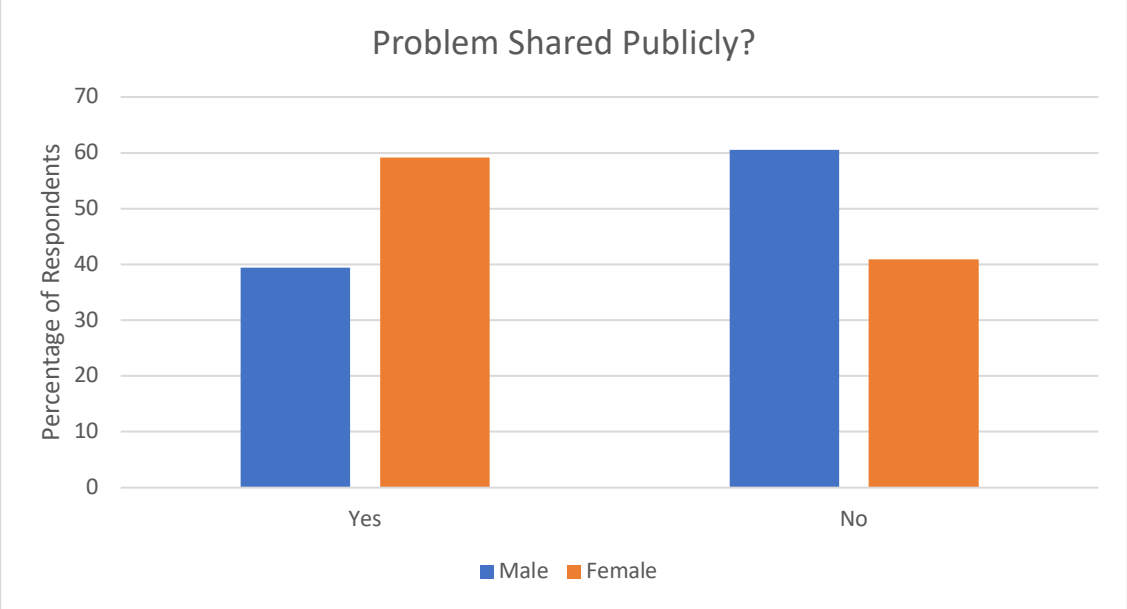


Figure 8 shows the proportion of male and female respondents who had experienced a friend disclosing a personal problem publicly on social media. A chi-square test of independence was performed to examine the relationship between gender and whether friends had shared a problem publicly on social media. The relationship between these variables was significant, X^2 (1, N = 351) = 13.615, *p* = .000. Females were more likely than males to report that friends had shared a problem publicly on social media.

Participants were then asked which social media platform(s) their friends used to share a problem publicly. Responses were analysed using content analysis. Participants could give more than one response: There were 92 responses given by 75 male respondents, 135 responses given by 112 female respondents, and 11 responses given by 10 no-gender respondents. Table 17 displays the frequency of responses and the percentage of respondents who gave each

answer, by gender. No-gender participants (*n* = 10) were excluded and are not included in the "Total" column. Table J4 displays all responses.

Table 17
Social media platforms used to share problems publicly

Response	Male (%)	Female (%)	Total (%)
Snapchat	44 (58.67)	78 (69.64)	122 (65.24)
Instagram	29 (38.67)	38 (33.93)	67 (35.83)
Facebook	14 (18.67)	14 (12.50)	28 (14.97)
Other	5 (6.67)	5 (4.46)	10 (5.35)

Note. Percentages in parentheses show the percentage of male or female respondents who gave each response, i.e. 58.67 of male respondents (*n* = 75) and 69.64% of female respondents (*n* = 112) listed "Snapchat" as one of their answers.

Figure 9
Social media platforms used to share problems publicly

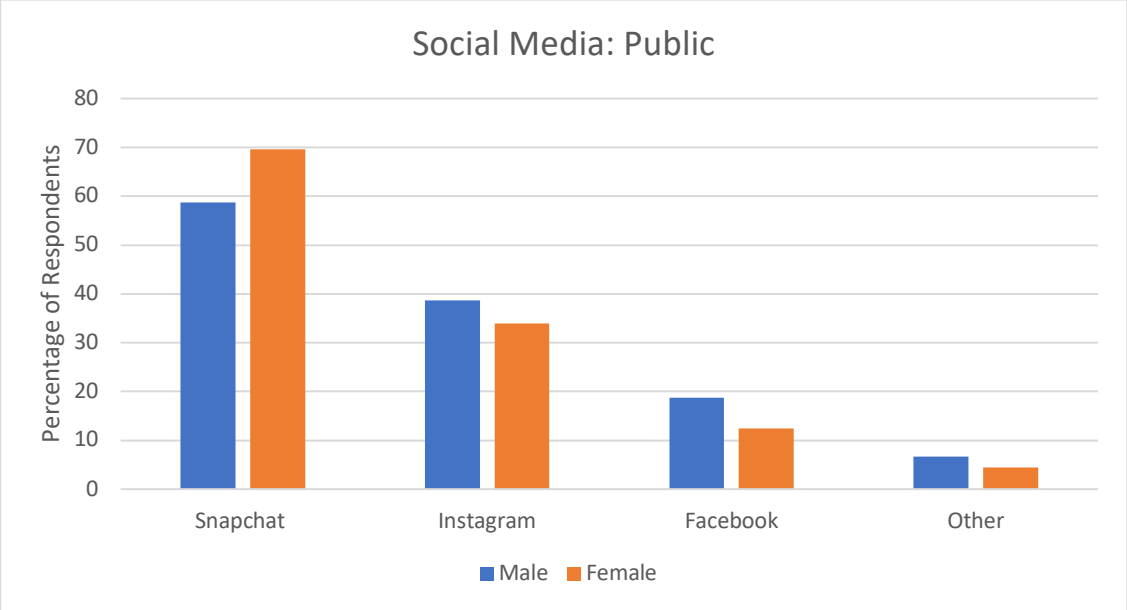


Figure 9 displays the social media platforms on which participants had experienced a public disclosure of a friend's personal problem. It shows the

percentage of male and female respondents who gave each answer. A higher proportion of females than males had experienced this phenomenon on Snapchat (70% and 59% respectively). A slightly higher proportion of males than females had experienced it on Instagram, Facebook, and other social media websites. However, more females than males responded to this question, reflecting the finding that more females than males reported having experienced this phenomenon.

4.4 Responses to a Serious Problem

What would you think?

Participants were asked to respond to two of a possible three vignettes, in which a friend discloses a problem relating to depression, anxiety, or self-harm. They were first asked what they would think when they heard the disclosure, by selecting from a multiple-choice list of responses. Results are displayed according to each vignette by gender, then by vignette with genders combined.

Responses by gender.

Table 18 displays the number of participants who responded to this question for each vignette, by gender.

Table 18
Thoughts: frequency of respondents to each vignette by gender

Gender	Depression	Anxiety	Self-harm
Male	119	114	107
Female	125	121	115
No-gender	11	21	23
Total	255	256	245

Table 19 displays the frequencies of each response to the vignettes, by gender. In parentheses is the percentage of male, female, and no-gender respondents to each vignette who selected the response. Figures 10-12 display the frequencies of participants who ticked each response, by gender.

Table 19

Thoughts in response to each vignette by gender

Response	Depression			Anxiety			Self-harm		
	Male (%)	Female (%)	No-gen (%)	Male (%)	Female (%)	No-gen (%)	Male (%)	Female (%)	No-gen (%)
This is a serious problem.	77 (64.71)	96 (76.80)	4 (36.36)	43 (37.72)	47 (38.84)	6 (28.57)	80 (74.77)	93 (80.87)	14 (60.87)
I'm worried about --.	63 (52.94)	92 (73.60)	6 (54.55)	50 (43.86)	80 (66.12)	7 (33.33)	56 (52.34)	92 (80.00)	11 (47.83)
I can help with solving this problem for --.	49 (41.18)	53 (42.40)	5 (45.45)	51 (44.74)	57 (47.11)	7 (33.33)	39 (36.45)	54 (46.96)	9 (39.13)
I should tell an adult about this.	37 (31.09)	58 (46.40)	4 (36.36)	44 (38.60)	57 (47.11)	7 (33.33)	52 (48.60)	69 (60.00)	9 (39.13)
-- has a mental health difficulty.	43 (36.13)	51 (40.80)	5 (45.45)	30 (26.32)	42 (34.71)	5 (23.81)	34 (31.78)	45 (39.13)	7 (30.43)
Something else.	11 (9.24)	9 (7.20)	3 (27.27)	10 (8.77)	14 (11.57)	2 (9.52)	7 (6.54)	14 (12.17)	4 (17.39)
-- should be embarrassed about this problem.	0 (0)	3 (2.40)	1 (9.09)	1 (0.88)	3 (2.48)	2 (9.52)	4 (3.74)	1 (0.87)	0 (0)

Figure 10

Thoughts in response to the depression vignette by gender

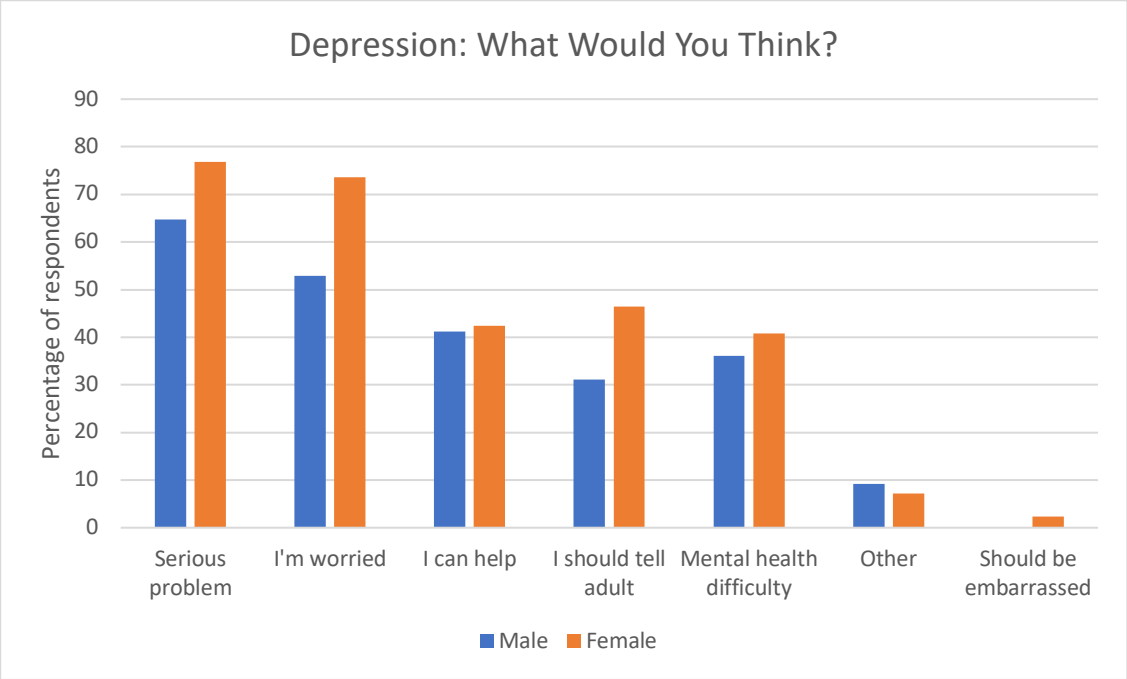


Figure 11

Thoughts in response to the anxiety vignette by gender

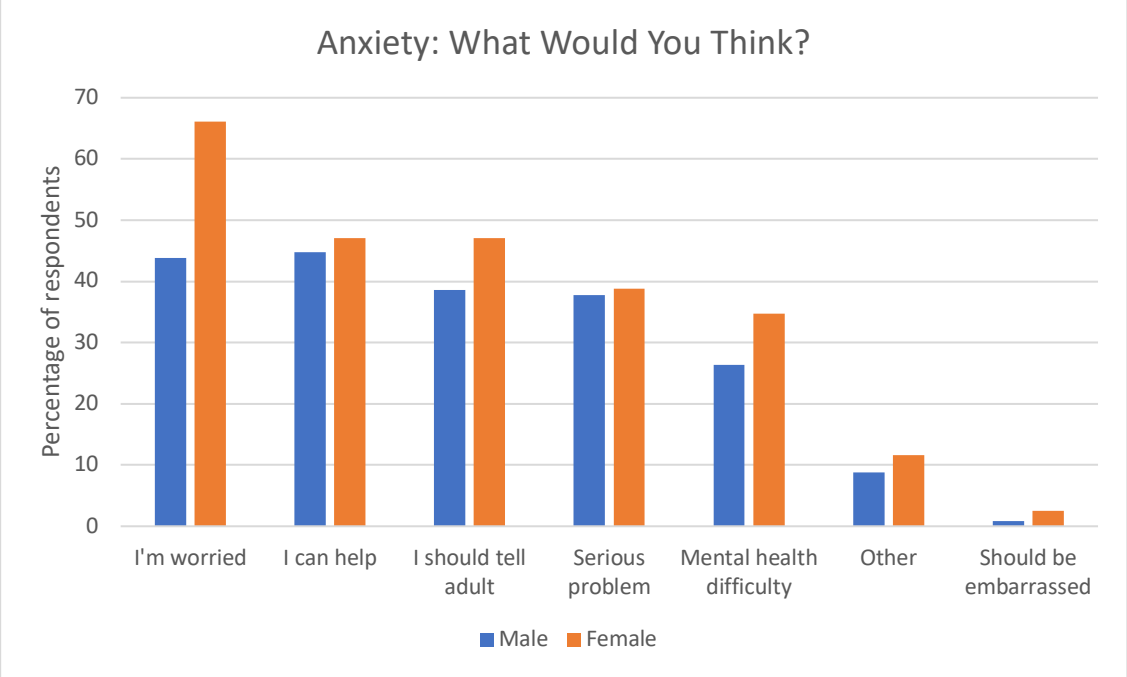
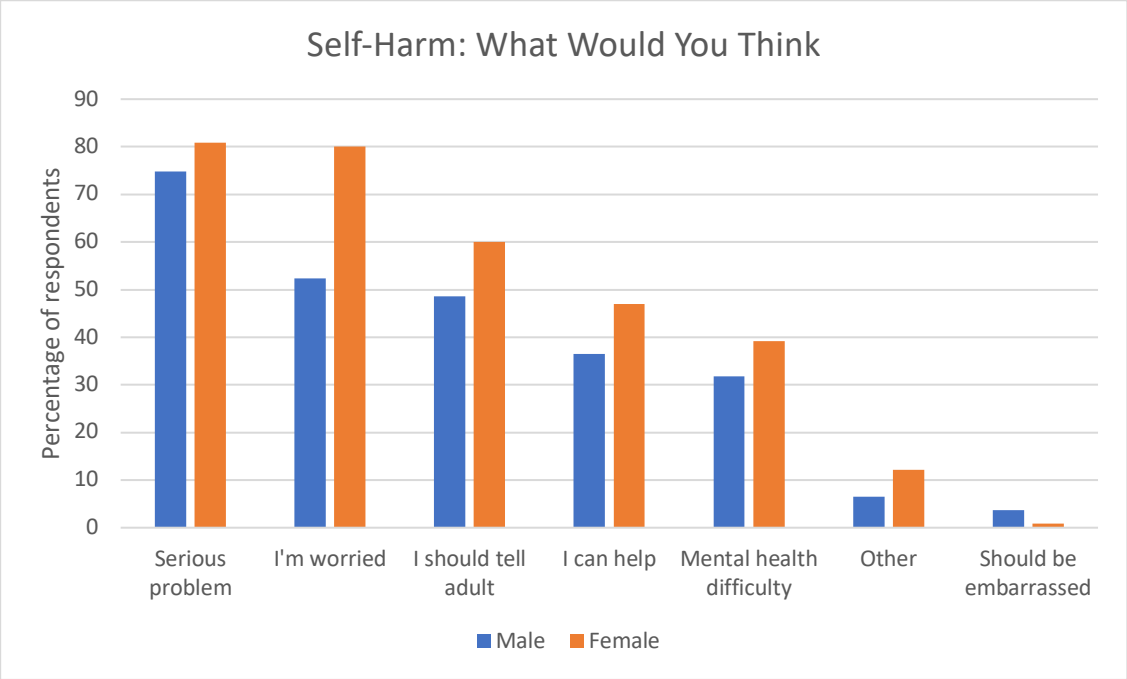


Figure 12

Thoughts in response to the self-harm vignette by gender



Responses by vignette.

Table 20 displays the frequency of responses and the percentage of total respondents to the depression vignette (*n* = 255), the anxiety vignette (*n* = 256), and the self-harm vignette (*n* = 245) who gave each response. Figure 13 displays the percentage of respondents who gave each response, by vignette.

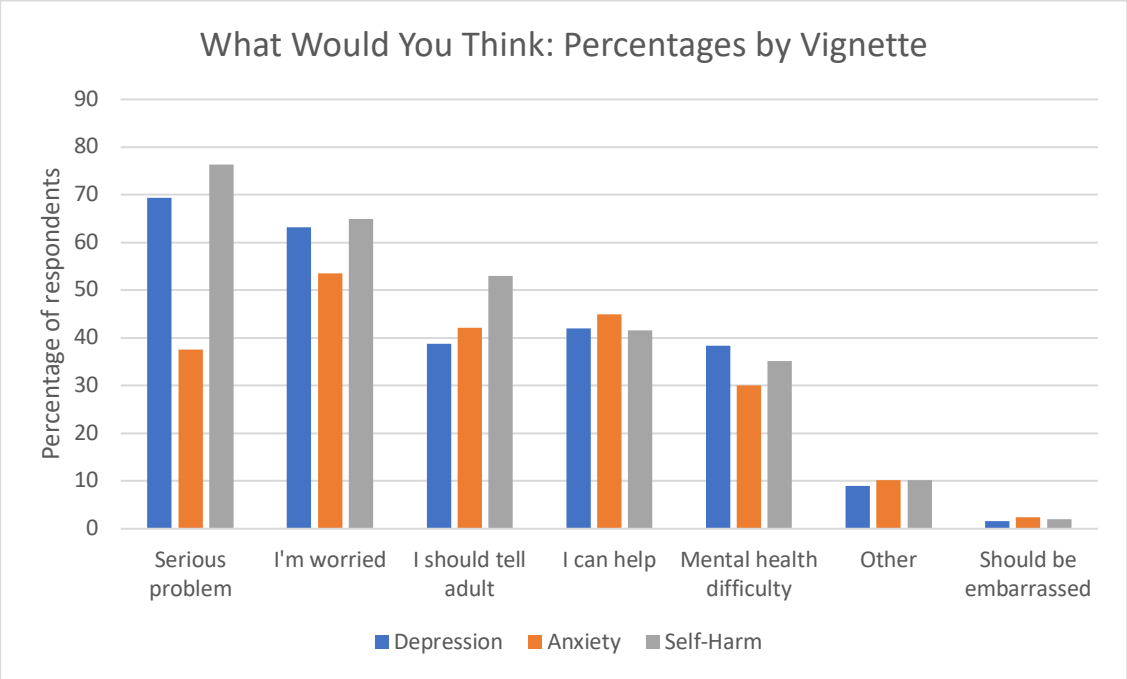
Table 20

Thoughts in response to each vignette by vignette

Response	Depression (%)	Anxiety (%)	Self-harm (%)	Total (%)
This is a serious problem.	177 (69.41)	96 (37.50)	187 (76.33)	460 (60.85)
I'm worried about --.	161 (63.14)	137 (53.52)	159 (64.90)	457 (60.45)
I should tell an adult about this.	99 (38.82)	108 (42.19)	130 (53.06)	337 (44.58)
I can help with solving this problem for --.	107 (41.96)	115 (44.92)	102 (41.63)	324 (42.86)
-- has a mental health difficulty.	99 (38.43)	77 (30.08)	86 (35.10)	262 (34.52)
Something else.	23 (9.02)	26 (10.16)	25 (10.20)	74 (9.79)
-- should be embarrassed about this problem.	4 (1.57)	6 (2.34)	5 (2.04)	15 (1.98)

Figure 13

Thoughts in response to each vignette by vignette



Tables 19-20 and Figures 10-13 show what participants would think in response to a peer disclosing a serious personal problem relating to mental illness. For the vignettes regarding depression and self-harm, participants were likely to worry about the character (63% and 65% respectively) and to report that the character was experiencing a serious problem (69% and 76% respectively). They displayed less concern for the character experiencing anxiety: 54% of respondents were worried and 38% felt it was a serious problem. Participants were also slightly less likely to describe the anxious character as having a mental health difficulty (30%) than the depressed (38%) and self-harming (35%) characters. Very few participants thought that the character should be embarrassed by their problem. Across most responses for all three vignettes, females were more likely to agree with the thought-responses provided in the questionnaire. The most marked gender difference was whether the respondent was worried about the friend, with females more likely to state that they would feel worried. Females were also more likely than males to think that they should tell an adult.

What would you say?

Participants were then asked what they would say to the friend in the vignette, by selecting from a multiple-choice list of responses. Results are displayed according to each vignette by gender, then by vignette with genders combined.

Responses by gender.

Table 21 displays the number of participants who responded to each vignette, by gender.

Table 21
Verbal response: frequency of respondents to each vignette by gender

Gender	Depression	Anxiety	Self-harm
Male	120	113	106
Female	125	121	115
No-gender	10	21	23
Total	255	255	244

Table 22 displays the frequencies of each response to the vignettes, by gender. In parentheses is the percentage of male, female, and no-gender respondents to

each vignette who selected the response. Figures 14-16 displays the frequencies of participants who selected each response, by gender.

Table 22

Verbal response to each vignette by gender

Response	Depression			Anxiety			Self-harm		
	Male (%)	Female (%)	No-gen (%)	Male (%)	Female (%)	No-gen (%)	Male (%)	Female (%)	No-gen (%)
You should tell an adult about this.	76 (63.33)	85 (68.00)	5 (50.00)	58 (51.33)	87 (71.90)	10 (47.62)	69 (65.09)	84 (73.04)	13 (56.52)
I'm worried about you.	62 (51.67)	96 (76.80)	6 (60.00)	49 (43.36)	74 (61.16)	7 (33.33)	56 (52.83)	85 (73.91)	8 (34.78)
Tell me more about how you're feeling.	53 (44.17)	102 (81.60)	5 (50.00)	62 (54.87)	95 (78.51)	7 (33.33)	47 (44.34)	86 (74.78)	11 (47.83)
You're still my friend.	67 (55.83)	85 (68.00)	6 (60.00)	49 (43.36)	69 (57.02)	6 (28.57)	58 (54.72)	78 (67.83)	11 (47.83)
Have you been thinking about suicide?	45 (37.50)	72 (57.60)	3 (30.00)	32 (28.32)	35 (28.93)	2 (9.52)	43 (40.57)	71 (61.74)	7 (30.43)
I won't tell anyone if you don't want me to.	39 (32.50)	40 (32.00)	5 (50.00)	35 (30.97)	47 (38.84)	5 (23.81)	32 (30.19)	49 (42.61)	6 (26.09)
We can solve this problem by ourselves.	12 (10.00)	14 (11.20)	1 (10.00)	20 (17.70)	13 (10.74)	4 (19.05)	9 (8.49)	11 (9.57)	2 (8.70)
Something else.	7 (5.83)	10 (8.00)	0 (0)	6 (5.31)	6 (4.96)	0 (0)	5 (4.72)	15 (13.04)	2 (8.70)
I can't help you with this problem.	4 (3.33)	7 (5.60)	1 (10.00)	9 (7.96)	4 (3.31)	1 (4.76)	7 (6.60)	7 (6.09)	3 (13.04)
You shouldn't tell anyone else about this.	7 (5.83)	2 (1.60)	2 (20.00)	6 (5.31)	1 (0.83)	0 (0)	7 (6.60)	2 (1.74)	3 (13.04)

Figure 14

Verbal response to the depression vignette by gender

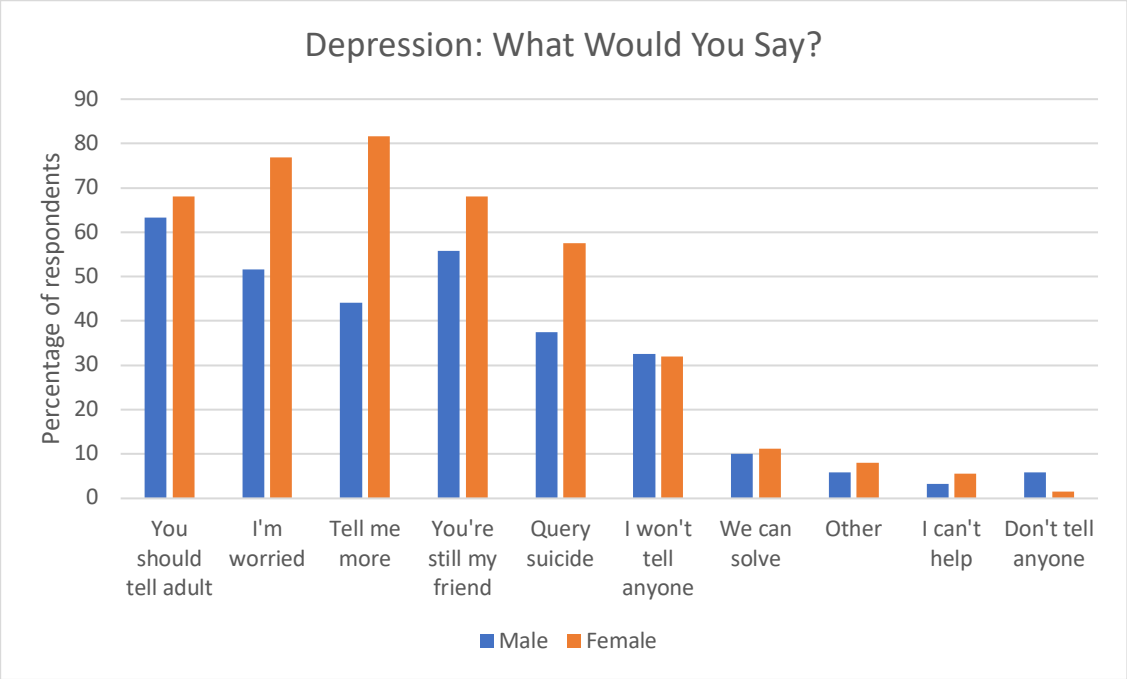


Figure 15

Verbal response to the anxiety vignette by gender

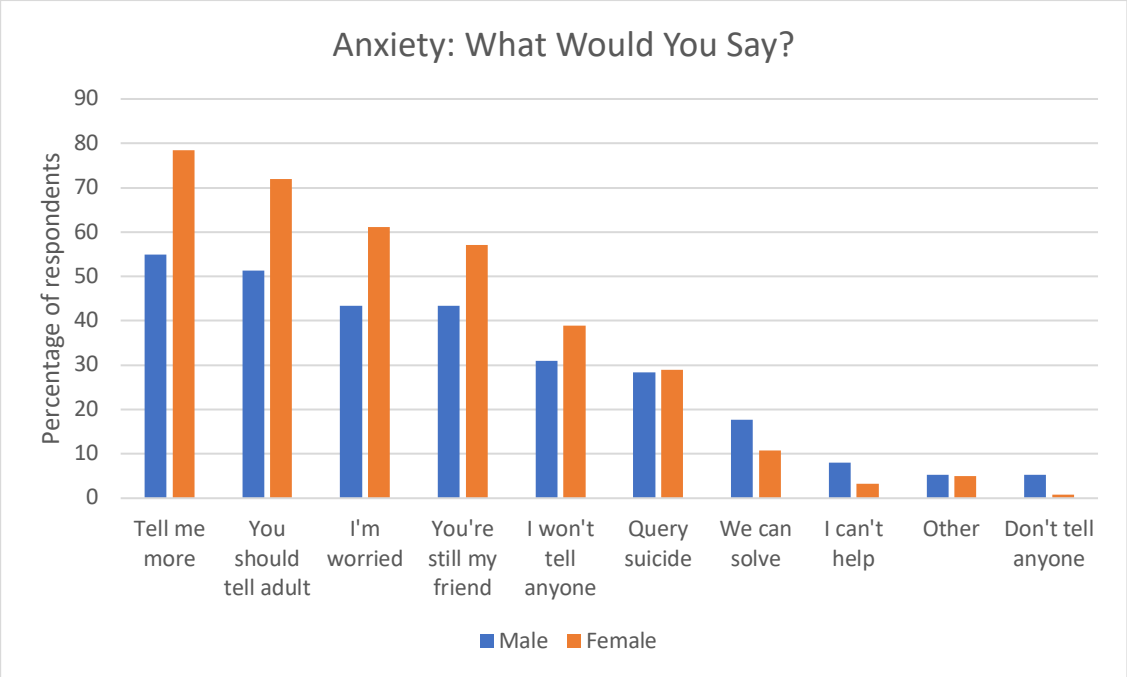
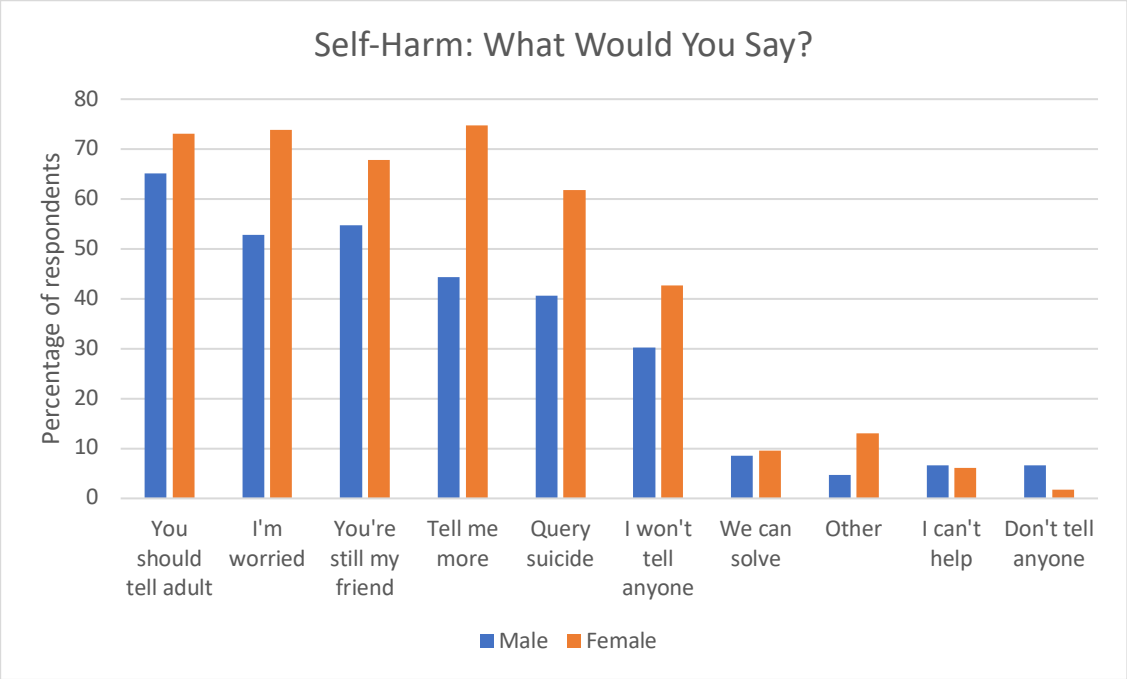


Figure 16

Verbal response to the self-harm vignette by gender



Responses by vignette.

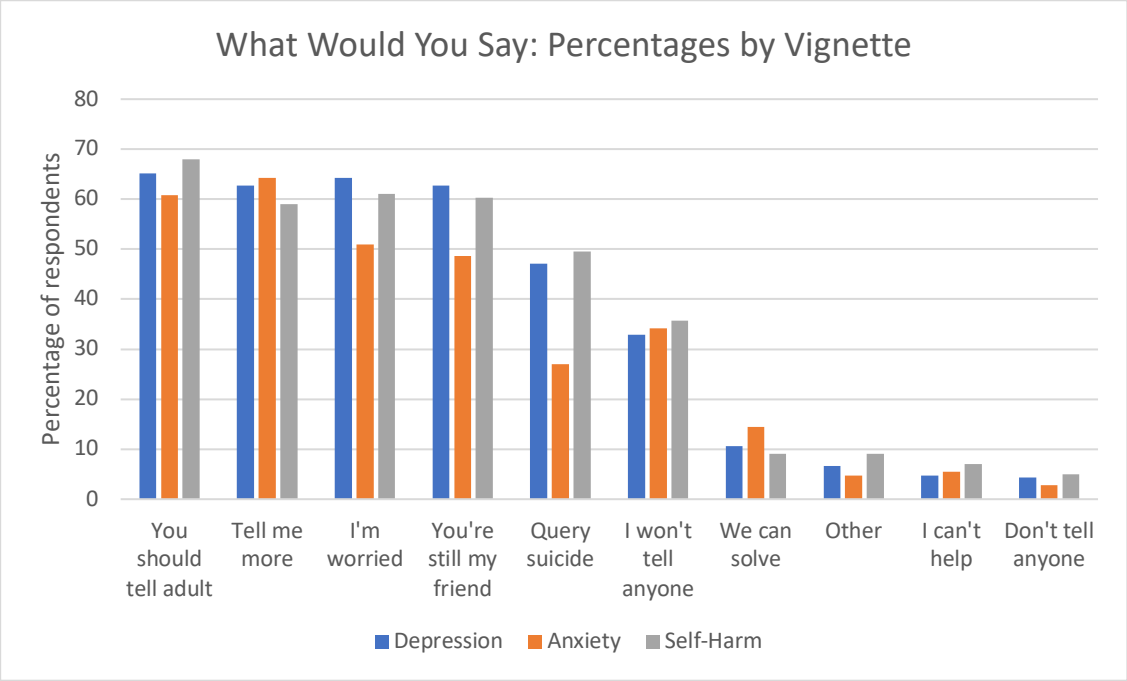
Table 23 displays the frequency of responses and the percentage of total respondents to the depression vignette (*n* = 255), the anxiety vignette (*n* = 255), and the self-harm vignette (*n* = 244) who gave each response. Figure 17 displays the percentage of respondents who gave each response, by vignette.

Table 23
Verbal response to each vignette by vignette

Response	Depression (%)	Anxiety (%)	Self-harm (%)	Total (%)
You should tell an adult about this.	166 (65.10)	155 (60.78)	166 (68.03)	487 (64.59)
Tell me more about how you're feeling.	160 (62.75)	164 (64.31)	144 (59.02)	468 (62.07)
I'm worried about you.	164 (64.31)	130 (50.98)	149 (61.07)	443 (58.75)
You're still my friend.	158 (62.75)	124 (48.63)	147 (60.25)	429 (56.90)
Have you been thinking about suicide?	120 (47.06)	69 (27.06)	121 (49.59)	310 (41.11)
I won't tell anyone about this if you don't want me to.	84 (32.94)	87 (34.12)	87 (35.66)	258 (34.22)
We can solve this problem by ourselves.	27 (10.59)	37 (14.51)	22 (9.02)	86 (11.41)
Something else.	17 (6.67)	12 (4.71)	22 (9.02)	51 (6.76)
I can't help you with this problem.	12 (4.71)	14 (5.49)	17 (6.97)	43 (5.70)
You shouldn't tell anyone else about this.	11 (4.31)	7 (2.75)	12 (4.92)	30 (3.98)

Figure 17

Verbal response to each vignette by vignette



Tables 22-23 and Figures 14-17 show what participants would say in response to a peer disclosing a serious personal problem relating to mental illness. For all three vignettes, around two thirds of respondents said they would encourage the character to tell an adult about the problem. About a third of respondents promised confidentiality. About half of the respondents asked the characters experiencing depression and self-harm if they had considered suicide. A small number of participants would tell the character that they cannot help them or that they should keep their problem secret. With a few exceptions, female participants were more likely to agree with the responses provided in the questionnaire. Roughly double the number of females than males would encourage the character experiencing depression or self-harm to tell them more about the problem. Asking the character to tell them more was the most popular response to the anxiety vignette for both males and females.

Would you do anything?

Participants were asked if they would do something in response to the character's disclosure. The options were "No," "Yes but only if -- agreed that I could," or "Yes even if -- did not want me to." Table 24 displays the frequencies and percentage of respondents who gave each answer, by gender. 'The "Total" rows display the frequency and percentage of respondents who gave each answer in response to each vignette. The "Total" column displays the frequency of respondents to each vignette, by gender.

Table 24
Acting with or without permission in response to each vignette

Vignette	Response			Total
	No	Yes if agreed	Yes if not agreed	
Depression				
Male (%)	12 (10.00)	57 (47.50)	51 (42.50)	120
Female (%)	4 (3.28)	60 (49.18)	58 (47.54)	122
No-gen (%)	2 (22.22)	6 (66.67)	1 (11.11)	9
Total (%)	18 (7.17)	123 (49.00)	110 (43.82)	251
Anxiety				
Male (%)	13 (11.61)	59 (52.68)	40 (35.71)	112
Female (%)	7 (5.83)	64 (53.33)	49 (40.83)	120
No-gen (%)	7 (35.00)	9 (45.00)	4 (20.00)	20
Total (%)	27 (10.71)	132 (52.38)	93 (36.90)	252
Self-harm				
Male (%)	5 (4.72)	46 (43.40)	55 (51.89)	106
Female (%)	3 (2.61)	54 (46.96)	58 (50.43)	115
No-gen (%)	3 (14.29)	11 (52.38)	7 (33.33)	21
Total (%)	11 (4.55)	111 (45.87)	120 (49.59)	242

Figure 18

Acting with or without permission in response to each vignette

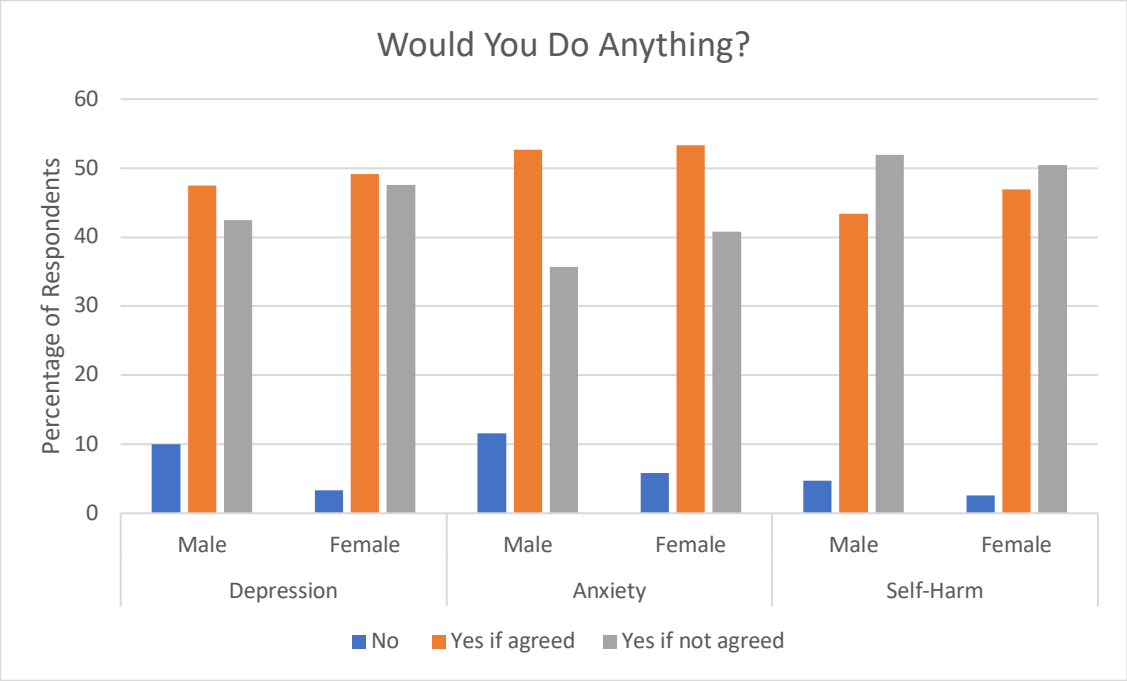


Figure 18 shows the percentage of male and female respondents who would or would not do something about each vignette-character's problem. For the characters experiencing depression and anxiety, the most frequently chosen response was to take action with the character's permission (49% and 52% respectively). When the character was self-harming, participants were most likely to act even if the character did not agree that they could (50%). Across all three problem-types, the descriptive statistics appeared to show that males were more likely to choose not to take action than females, and that females were slightly more likely than males to take action without the character's permission.

Chi-square tests of independence were performed to examine whether there were significant differences between males and females in whether the participant took action based on the character's problem, with or without permission. The results are presented in Table 25. No significant differences were found.

Table 25
Whether action was taken and gender: significance tests

Vignette	Chi-square test of independence	Significance
Depression	X^2 (2, N = 242) = 4.510, *p* = .105	No
Anxiety	X^2 (2, N = 232) = 2.641, *p* = .267	No
Self-harm	X^2 (2, N = 221) = .855, *p* = .652	No

Open responses.

Outline of analysis.

Open questions allowed participants to give answers that had not been covered in the multiple-choice options when asked what they would think and say in response to the disclosure in the vignettes. If participants stated that they would do something about the character's problem, they were also given an open question asking what they would do. The answers to these three open questions were combined to establish participants' overall response to the vignettes. The responses were analysed using basic content analysis (Section 3.6). Table 26 displays the number of male, female, and no-gender respondents to each vignette, and the number of codes generated for each vignette.

Table 26
Content analysis: frequency of respondents and codes for each vignette

	Respondents				
Vignette	Male	Female	No-gen	Total	Codes
Depression	105	116	9	230	375
Anxiety	91	111	11	213	337
Self-harm	93	116	17	226	368

The findings presented in this section are a summary of the results of the content analysis. Tables J5-J8 contain a full list of codes and code frequencies. Codes were combined into groups under three overarching headings: "How to react?", "What to do?", and "Whom to tell?" (Table 27).

For each heading, results are first displayed according to each vignette by gender. No-gender responses were excluded and are not included in the "Total" columns. See Tables J9-J17 for all responses under these headings. Results are then displayed by vignette with all three gender-groups combined.

Table 27
Grouped content analysis codes under overarching headings

Group	Content analysis code
Heading 1: How to react	
Find out more	Ask after feelings Explore the problem
Be a friend	Be there for him/her Give encouragement or boost confidence Show understanding
Negative	Negative or dismissive statements
Discourage	Discourage the activity
Could get worse	Suicide risk It could get worse or I will act if it gets worse
Heading 2: What to do?	
Tell someone (vague)	Tell an (unidentified) adult Tell someone
Accompany	Go with him/her to get help
I can help	I want to or can help
Offer practical help	Offer practical help
He/She needs help	He/She needs help (i.e. not from me) Needs to talk to or see someone else
Confidential	Keep it confidential (even if telling adult)
Heading 3: Whom to tell?	
Tell school	Tell a member of school staff
Tell family	Tell his/her family member Tell my family member
Tell friends	Speak to his/her friends
Tell professional	Seek professional help
Find help online	Seek online help

Heading 1: How to react?

Responses by gender.

This section outlines the responses coded under the heading "How to react?" for each vignette. Table 28 displays the frequency of responses and the percentages of male and female respondents who gave each answer, in response to each vignette. Figures 19-21 display the frequency of each code group, by gender.

Table 28
Content analysis code frequencies by gender: How to react?

Code group	Depression		Anxiety		Self-Harm	
	Male (%)	**Female (%)**	**Male (%)**	**Female (%)**	**Male (%)**	**Female (%)**
Be a friend	31 (29.52)	21 (18.10)	8 (8.79)	11 (9.91)	10 (10.75)	17 (14.66)
Find out more	26 (24.76)	17 (14.66)	5 (5.49)	7 (6.31)	4 (4.30)	20 (17.24)
Could get worse	1 (0.95)	5 (4.31)	1 (1.10)	4 (3.60)	3 (7.53)	6 (5.17)
Discourage	4 (3.81)	0 (0)	6 (6.59)	1 (0.90)	7 (7.53)	5 (4.31)
Negative	0 (0)	0 (0)	4 (4.40)	2 (1.80)	4 (4.30)	2 (1.72)

Note. Percentages in parentheses show the percentage of male or female respondents who gave each response, i.e. 29.52% of male respondents to the depression vignette (n = 105) and 18.10% of female respondents to the depression vignette (n = 116) gave an answer relating to the code group "Be a friend." Frequencies of respondents to each vignette by gender can be found in Table 26.

Figure 19

Content analysis: reactions to the depression vignette

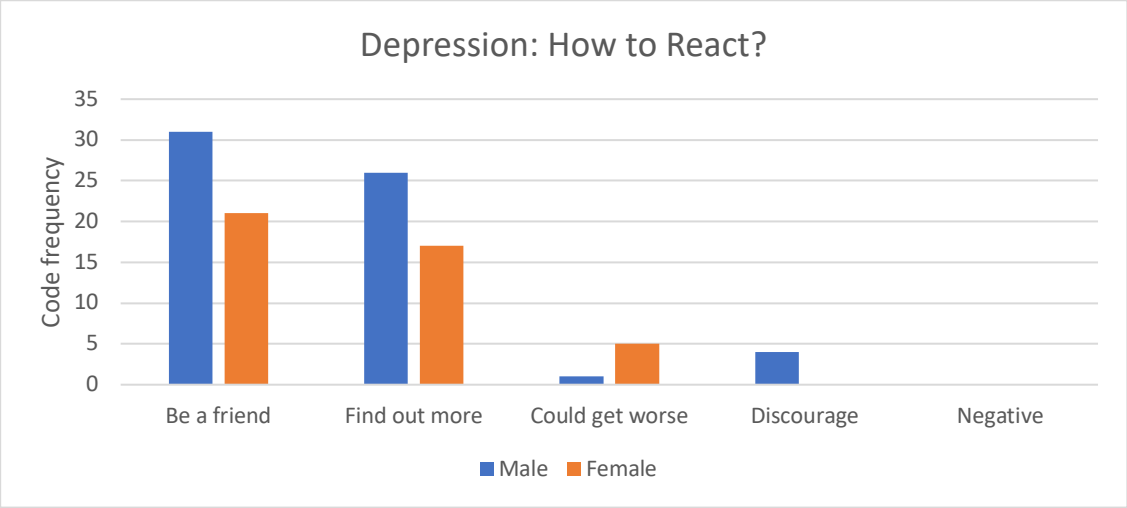


Figure 20

Content analysis: reactions to the anxiety vignette

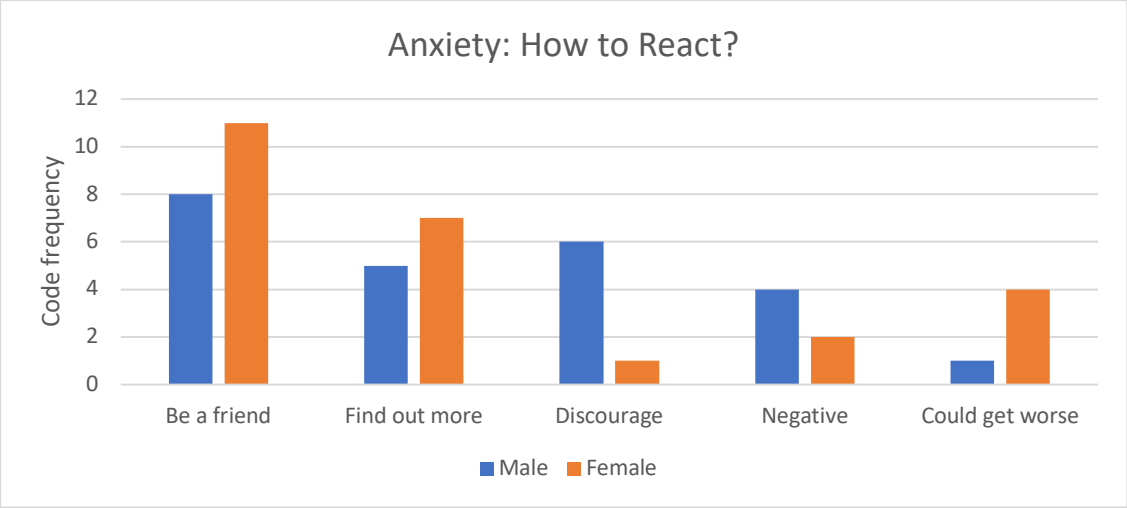
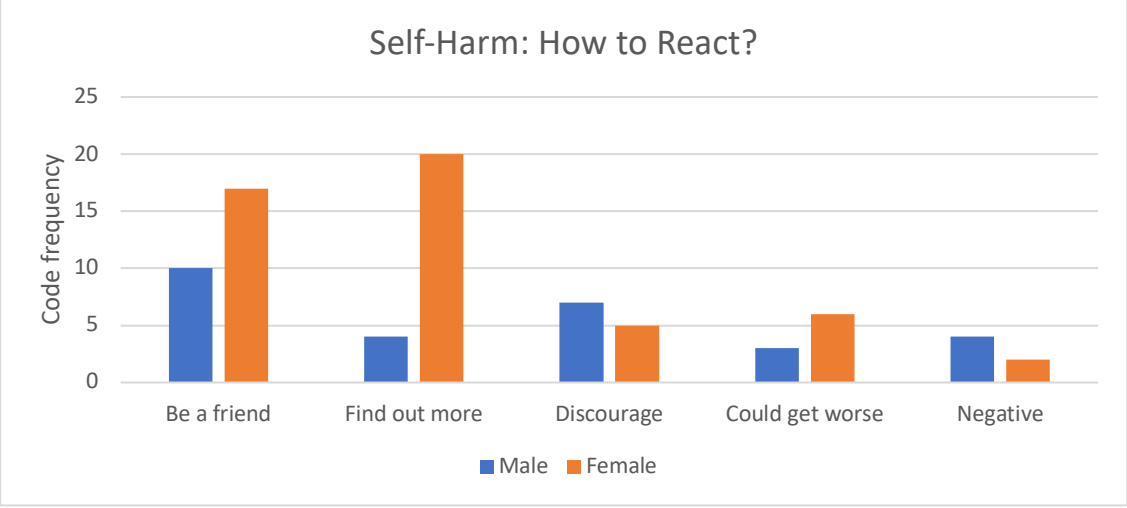


Figure 21

Content analysis: reactions to the self-harm vignette



Responses by vignette.

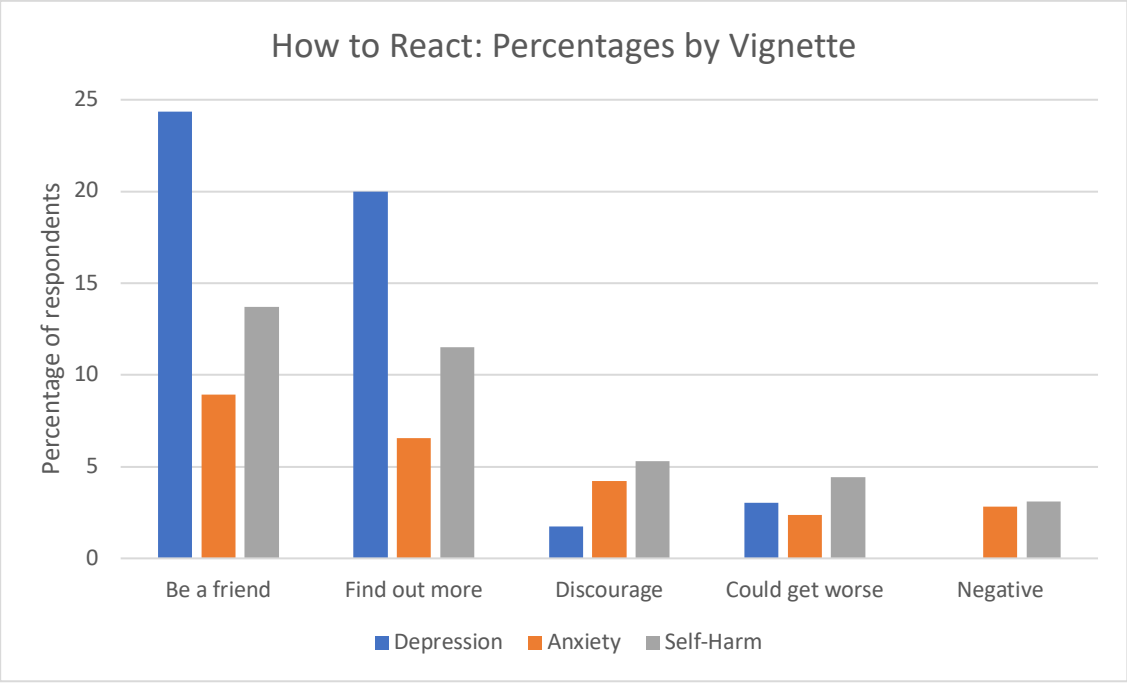
Table 29 displays the frequency of responses and the percentage of total respondents to each vignette, who gave each response. Figure 22 displays the percentage of respondents who gave each response, by vignette.

Table 29
Content analysis code frequencies by vignette: How to react?

Code group	Depression (%)	Anxiety (%)	Self-harm (%)	Total (%)
Be a friend	56 (24.34)	19 (8.92)	31 (13.72)	106 (15.84)
Find out more	46 (20.00)	14 (6.57)	26 (11.50)	86 (12.85)
Discourage	4 (1.74)	9 (4.23)	12 (5.31)	25 (3.74)
Could get worse	7 (3.04)	5 (2.35)	10 (4.42)	22 (3.29)
Negative	0 (0)	6 (2.82)	7 (3.10)	13 (1.94)

Note. Percentages in parentheses show the percentage of male or female respondents who gave each response. Frequencies of respondents to each vignette by gender can be found in Table 26.

Figure 22
Content analysis: reactions to each vignette



Summary.

Tables 28-29 and Figures 19-22 display the results of the content analysis of participants' responses to open questions; they display the codes relating to how the participant would react to the character's disclosure. Across all three vignettes, participants were most likely to respond by being a friend: that is, showing understanding of the problem and giving encouragement. Participants were also likely to respond by asking the character to tell them more about the problem. The depression vignette elicited a much higher frequency and proportion of such responses from both males and females than the anxiety and self-harm vignettes. In response to the anxiety and self-harm vignettes, some participants responded by discouraging the activity (4% and 5% respectively). No negative comments were given in response to the depression vignette, but some participants responded negatively to disclosures of anxiety and self-harm, for example by making dismissive comments (3% for both). Males were more likely than females to discourage the activity and give negative comments in response to the vignettes.

Heading 2: What to do?

This section outlines the responses coded under the heading "What to do?" for each vignette. Table 30 displays the frequency of responses and the percentages of male and female respondents who gave each answer in response to each vignette. Figures 23-25 display the frequency of each code group, by gender.

Table 30
Content analysis code frequencies by gender: What to do?

Code group	Depression		Anxiety		Self-Harm	
	Male (%)	**Female (%)**	**Male (%)**	**Female (%)**	**Male (%)**	**Female (%)**
Tell someone (unspecified)[a]	20 (19.05)	53 (45.69)	46 (50.55)	71 (63.96)	46 (49.46)	67 (57.76)
He/She needs help	30 (28.57)	15 (12.93)	10 (10.99)	23 (20.72)	5 (5.38)	24 (20.69)
Accompany	11 (10.48)	8 (6.90)	3 (3.30)	0 (0)	1 (1.08)	5 (4.31)
I can help	1 (0.95)	15 (12.93)	7 (7.69)	12 (10.81)	8 (8.60)	19 (16.38)
Offer practical help	9 (8.57)	3 (2.59)	2 (2.20)	4 (3.60)	4 (4.30)	1 (0.86)
Confidential	1 (0.95)	0 (0)	2 (2.20)	3 (2.70)	1 (1.08)	3 (2.59)

[a] This refers to answers which did not specify who would be told, e.g. "Tell someone" or "Tell an adult."

Note. Percentages in parentheses show the percentage of male or female respondents who gave each response. Frequencies of respondents to each vignette by gender can be found in Table 26.

Figure 23

Content analysis: actions taken in response to the depression vignette

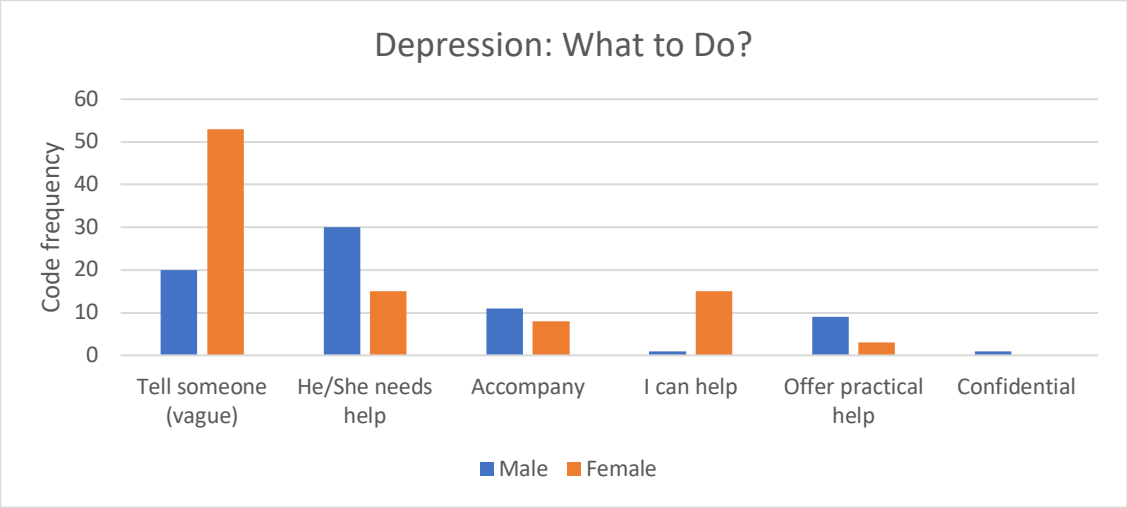


Figure 24

Content analysis: actions taken in response to the anxiety vignette

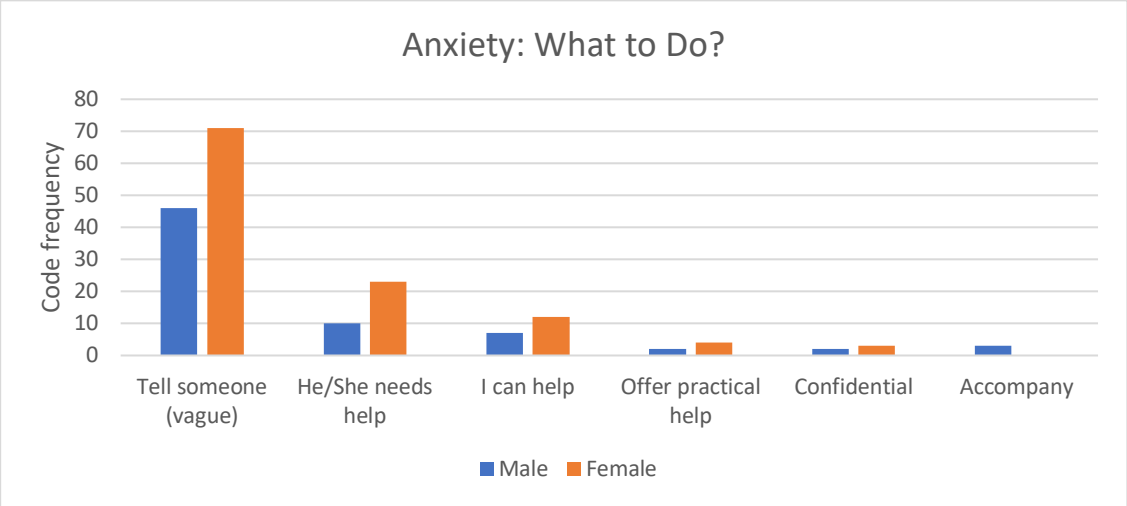
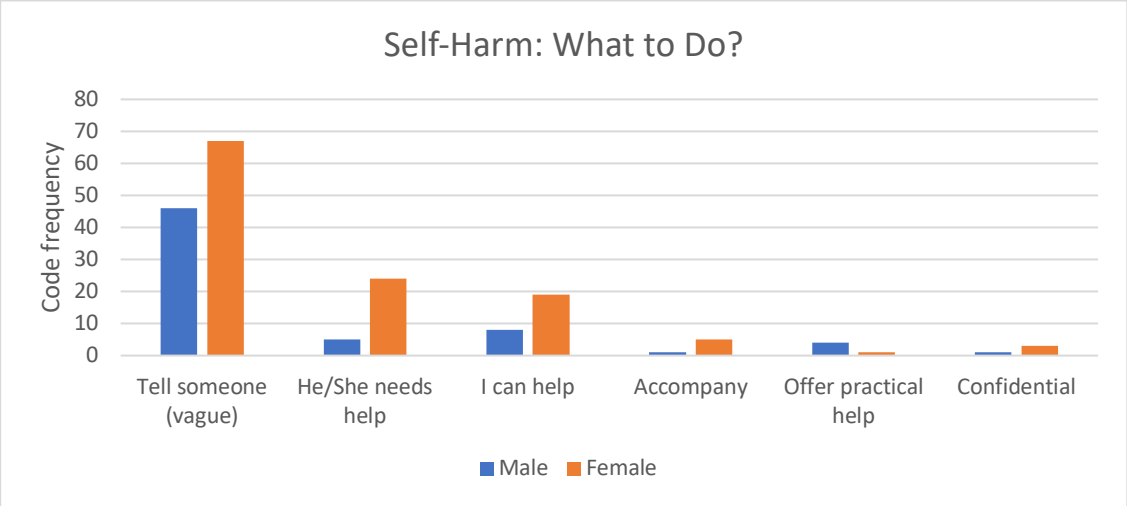


Figure 25

Content analysis: actions taken in response to the self-harm vignette



Responses by vignette.

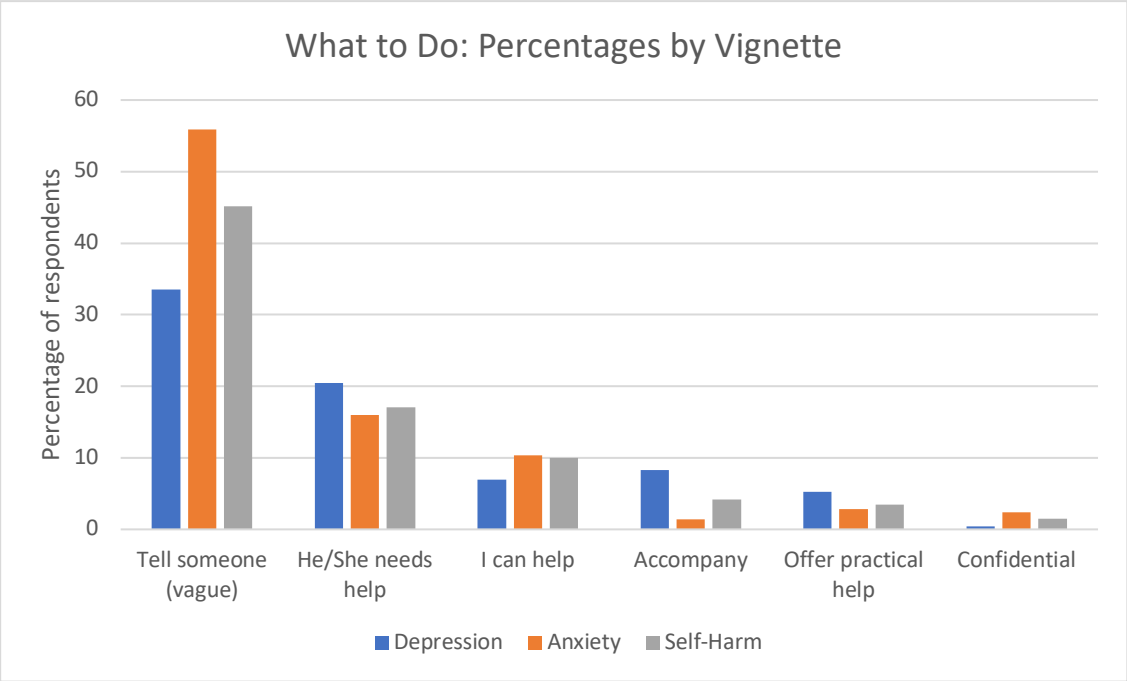
Table 31 displays the frequency of responses and the percentage of total respondents to each vignette, who gave each response. Figure 26 displays the percentage of respondents who gave each response, by vignette.

Table 31
Content analysis code frequencies by vignette: What to do?

Code group	Depression (%)	Anxiety (%)	Self-harm (%)	Total (%)
Tell someone (vague)	77 (33.48)	119 (55.87)	121 (53.54)	317 (47.38)
He/She needs help	47 (20.43)	34 (15.96)	33 (14.60)	114 (17.04)
I can help	16 (6.96)	22 (10.33)	29 (12.83)	67 (10.01)
Accompany	19 (8.26)	3 (1.41)	6 (2.65)	28 (4.19)
Offer practical help	12 (5.22)	6 (2.82)	5 (2.21)	23 (3.44)
Confidential	1 (0.43)	5 (2.35)	4 (1.77)	10 (1.49)

Note. Percentages in parentheses show the percentage of male or female respondents who gave each response. Frequencies of respondents to each vignette by gender can be found in Table 26.

Figure 26
Content analysis: actions taken in response to each vignette



Summary.

Tables 30-31 and Figures 23-26 display the results of the content analysis of participants' responses to open questions; they display the codes relating to intended actions in response to the character's disclosure. For all three vignettes, the most popular response within this category was to tell someone (unidentified or vague) about the character's problem. Around a third of respondents gave this answer in response to the depression vignette, and around half of respondents in response to the anxiety and self-harm vignettes. It should be noted that these results do not include answers which specified whom the respondent would tell. Almost double the number of females than males stated that they would tell someone (unidentified) about the character with depression. More females than males also stated that they would be able to or wanted to help the character. This gender difference was most pronounced in response to the depression vignette (13% females compared to 1% males). With the exception of the anxiety vignette, males were more likely than females to offer practical support to the character. However, the low frequency of responses for each code means that these gender differences should be interpreted with caution.

Heading 3: Whom to tell?

Responses by gender.

This section outlines the responses coded under the heading “Whom to tell?” for each vignette. Table 32 displays the frequency of responses and the percentages of male and female respondents who gave each answer, in response to each vignette. Figures 27-29 display the frequency of each code group, by gender.

Table 32
Content analysis code frequencies by gender: Whom to tell?

Code group	Depression		Anxiety		Self-harm	
	Male (%)	**Female (%)**	**Male (%)**	**Female (%)**	**Male (%)**	**Female (%)**
Tell school	10 (9.52)	22 (18.97)	7 (7.69)	9 (8.11)	12 (12.90)	10 (8.62)
Tell family	8 (7.61)	24 (20.69)	17 (18.68)	24 (21.62)	20 (21.51)	12 (10.34)
Tell professional	9 (8.57)	3 (2.59)	4 (4.40)	2 (1.80)	4 (4.30)	1 (0.86)
Tell friends	2 (1.90)	1 (0.86)	2 (2.20)	0 (0)	1 (1.08)	0 (0)
Find help online	0 (0)	0 (0)	1 (1.10)	3 (2.70)	0 (0)	1 (0.86)

Note. Percentages in parentheses show the percentage of male or female respondents who gave each response. Frequencies of respondents to each vignette by gender can be found in Table 26.

Figure 27

Content analysis: whom to tell in response to the depression vignette

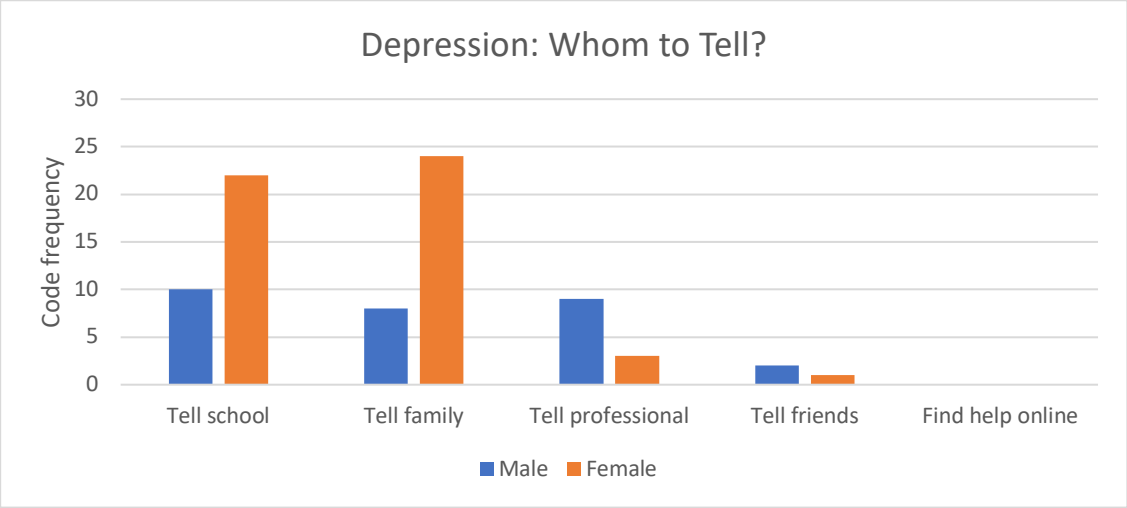


Figure 28

Content analysis: whom to tell in response to the anxiety vignette

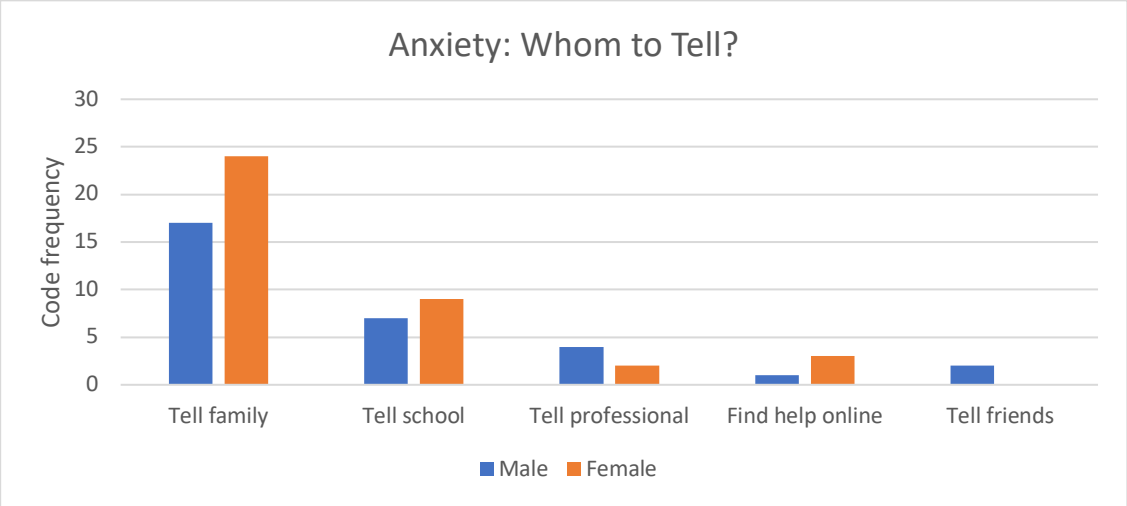
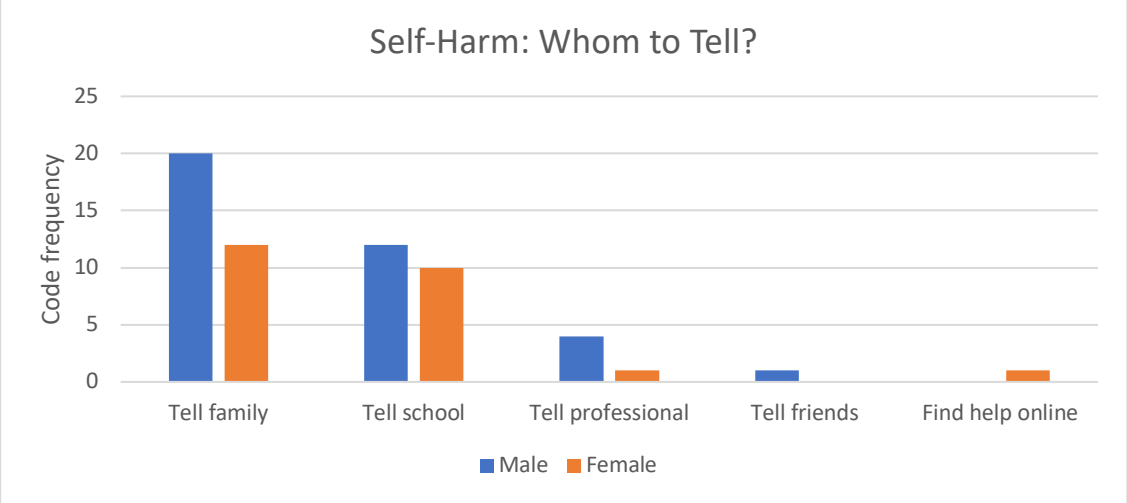


Figure 29

Content analysis: whom to tell in response to the self-harm vignette



Responses by vignette.

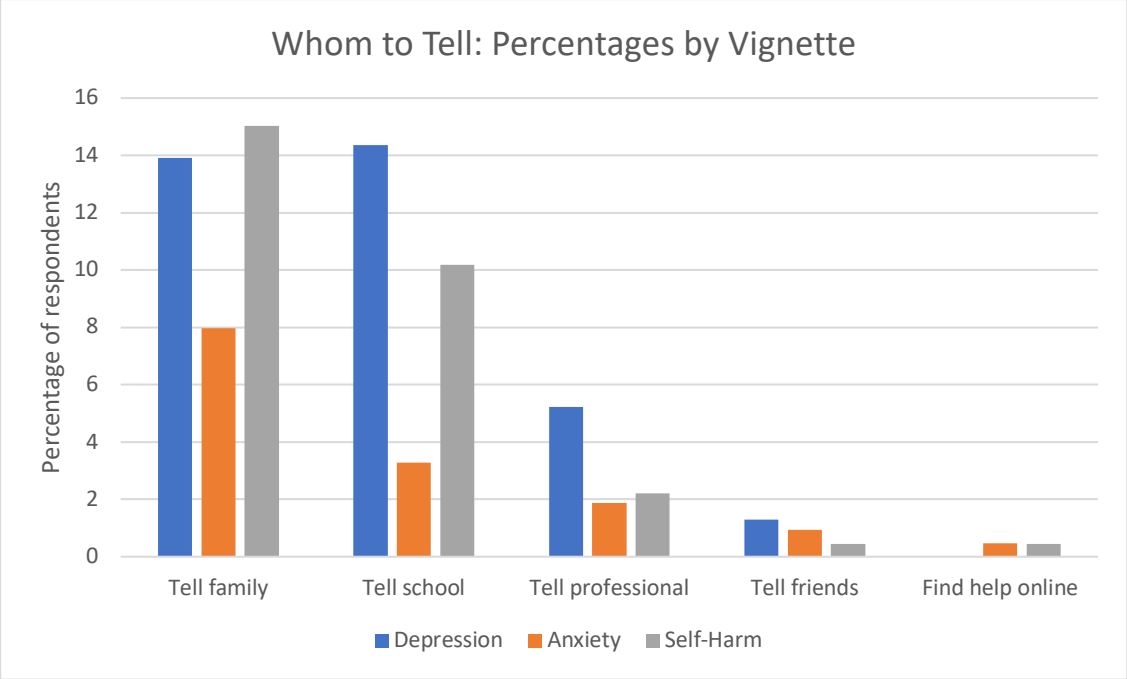
Table 33 displays the frequency of responses and the percentage of total respondents to each vignette, who gave each response. Figure 30 displays the percentage of respondents who gave each response, by vignette.

Table 33
Content analysis code frequencies by vignette: Whom to tell?

Code group	Depression (%)	Anxiety (%)	Self-harm (%)	Total (%)
Tell family	32 (13.91)	42 (19.72)	34 (15.04)	108 (16.14)
Tell school	33 (14.35)	18 (8.45)	23 (10.18)	74 (11.06)
Tell professional	12 (5.22)	6 (2.82)	5 (2.21)	23 (3.44)
Tell friends	3 (1.30)	2 (0.94)	1 (0.44)	6 (0.90)
Find help online	0 (0)	4 (1.88)	1 (0.44)	5 (0.75)

Note. Percentages in parentheses show the percentage of male or female respondents who gave each response. Frequencies of respondents to each vignette by gender can be found in Table 26.

Figure 30
Content analysis: whom to tell in response to each vignette



Summary.

Tables 32-33 and Figures 27-30 display the results of the content analysis of participants' responses to open questions; they display the codes relating to whom the participant would tell about the character's disclosure, if they specified to whom they would speak. "Family members" was the most common response to the anxiety and self-harm vignettes (20% and 15% respectively). This included the participant telling the character's family or a member of their own family. Talking to a member of school staff was the second most common response to the anxiety and self-harm vignettes (8% and 10% respectively). Telling family and school staff were equally popular in response to the depression vignette (14%). A few participants said that they would tell a professional or the character's other friends about the problem. Females were twice as likely as males to tell school staff or family members about the character's depression, and males were twice as likely as females to tell a family member about the character's self-harm. Although the response was not frequently given, males were more likely than females to talk to a professional about the character's problem across all vignettes. Otherwise, responses were fairly similar across both genders.

4.5 Confidence in Responding to a Serious Problem

Saying the right thing.

Participants were asked how confident they were that they had said the right thing to the vignette-character on a scale from 0 (*not at all confident*) to 10 (*very confident*). Table 34 displays the mean answers and standard deviations (SDs) for the response to each vignette, by gender. The "Total" rows display the means and SDs for all gender-groups combined, for each vignette. The "Total" column displays the number of respondents to each vignette, by gender.

Table 34
Confidence in saying the right thing in response to each vignette

Vignette	Mean	SD	Total
Depression			
Male	7.61	1.87	119
Female	7.01	1.73	123
No-gender	7.10	1.79	10
Total	7.29	1.82	252
Anxiety			
Male	7.35	2.03	110
Female	7.14	1.84	121
No-gender	6.86	2.06	21
Total	7.21	1.94	252
Self-harm			
Male	7.63	1.93	103
Female	7.21	1.87	116
No-gender	7.35	2.10	23
Total	7.40	1.92	242

Statistically significant differences in confidence between male and female responses were tested using one-way ANOVA for each vignette (Table 35). A significant difference according to gender was found for the depression vignette, with males reporting higher confidence than females.

Table 35

Gender and confidence in saying the right thing: significance tests

Vignette	One-way ANOVA	Significance
Depression	$F(1,240) = 6.636$, $p = .011$	Yes
Anxiety	$F(1,229) = .710$, $p = .400$	No
Self-harm	$F(1,217) = 2.727$, $p = .100$	No

Figure 31

Confidence in saying the right thing in response to each vignette

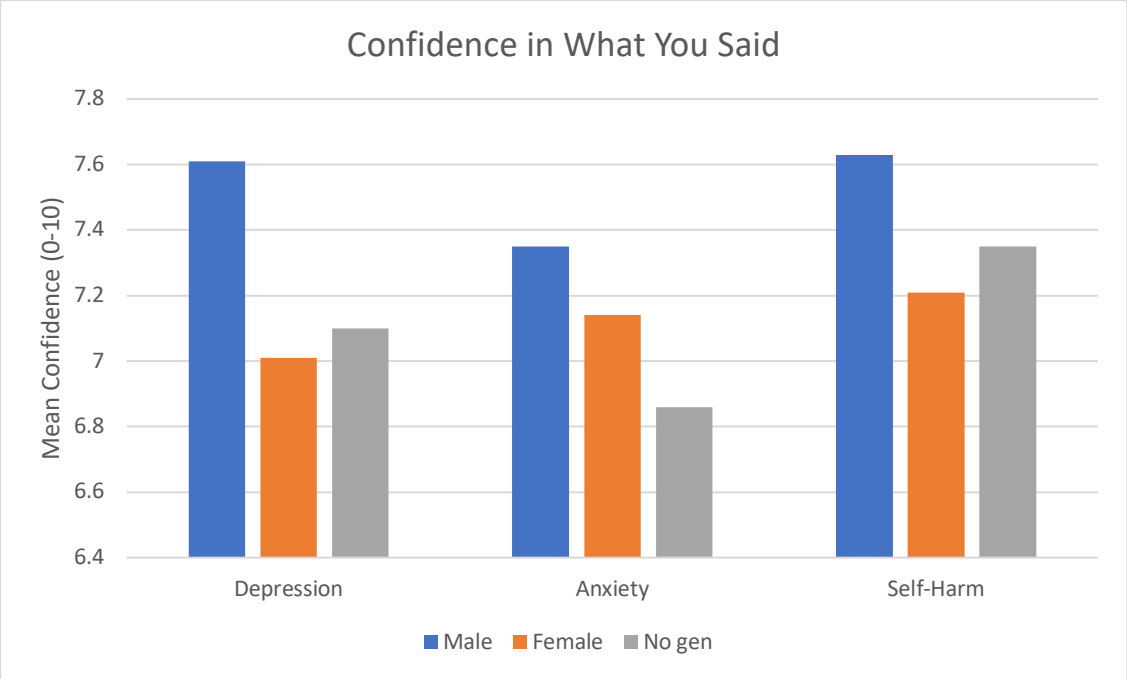


Figure 31 shows participants' mean responses to how confident they were that they had said the right thing to each vignette-character, by gender. All means were between 6.8 and 7.7, meaning that there was only slight variation between them. Across all vignettes, males were more confident than females that they had given the right verbal response. There was a statistically significant gender difference for the depression vignette only. Males were least confident in responding to the anxiety vignette, while females were least confident responding to the depression vignette. Both males and females were most confident responding to the self-harm vignette.

Doing the right thing.

Participants were asked how confident they were that they had done the right thing for the vignette-character on a scale from 0 (*not at all confident*) to 10 (*very confident*). Table 36 displays the mean answers and SDs for the response to each vignette, by gender. The "Total" rows display the means and SDs for all gender-groups combined, for each vignette. The "Total" column displays the number of respondents to each vignette, by gender.

Table 36
Confidence in doing the right thing in response to each vignette

Vignette	Mean	SD	Total
Depression			
Male	7.76	1.81	117
Female	7.28	1.85	122
No-gender	7.22	1.99	9
Total	7.50	1.84	248
Anxiety			
Male	7.36	2.05	111
Female	7.28	1.80	116
No-gender	6.65	2.35	20
Total	7.27	1.97	247
Self-harm			
Male	7.65	1.68	105
Female	7.32	1.79	114
No-gender	7.14	2.68	22
Total	7.44	1.84	241

Statistically significant differences in confidence between male and female responses were tested using one-way ANOVA for each vignette (Table 37). A significant difference according to gender was found for the depression vignette, with males reporting higher confidence than females.

Table 37
Gender and confidence in doing the right thing: significance tests

Vignette	One-way ANOVA	Significance
Depression	$F(1,237) = 4.142$, $p = .043$	Yes
Anxiety	$F(1,225) = .088$, $p = .767$	No
Self-harm	$F(1,217) = 1.989$, $p = .160$	No

Figure 32

Confidence in doing the right thing in response to each vignette

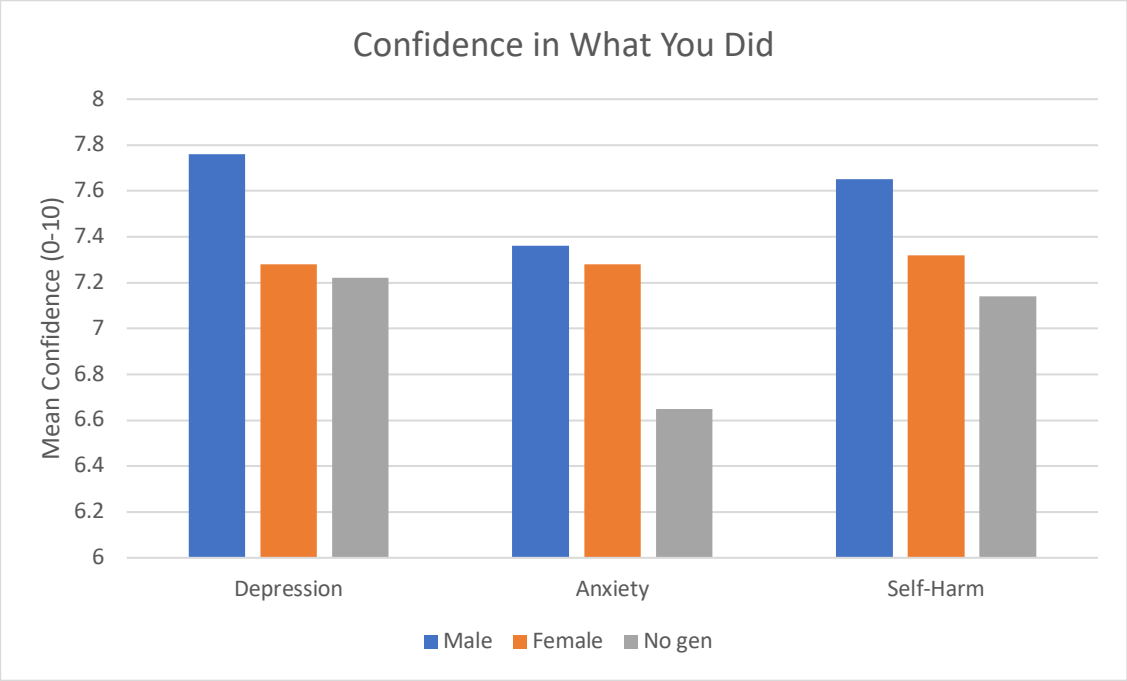


Figure 32 shows participants' mean responses to how confident they were that they had done the right thing in response to each vignette-character's disclosure, by gender. All means were between 6.6 and 7.8, meaning that there was only slight variation between them. Across all vignettes, males were more confident than females that they had taken the right action. There was a statistically significant gender difference for the depression vignette only. Both genders were least confident in responding to the anxiety vignette (although females were equally confident responding to the depression vignette). Males were most confident responding to the depression vignette, while females were most confident responding to the self-harm vignette, by a small margin.

5. Phase 1 Discussion

This section analyses further the Phase 1 findings and relates them to relevant literature. It is structured by RQ. RQ1.4 (gender differences) is discussed throughout.

5.1 Types of Problem Disclosed by Peers (RQ1.1a and RQ1.1b)

Key findings.

- A high proportion of participants regularly discussed problems with peers on a range of topics.
- The most frequently discussed topics were problems with school and friendships.
- Females reported more frequent discussions than males about peers' problems with friendships, family, and mental health.
- A third of respondents had struggled to help a friend with a problem relating to home life.
- A quarter of female respondents had struggled to help a friend with depression, self-harm, or suicidal thoughts.

Analysis.

A high proportion of the participants discussed a range of problems with their peers. Three quarters of respondents (78%) discussed problems relating to school often or sometimes. The least frequently discussed category – mental health – was nevertheless discussed often or sometimes by a third of the respondents. The frequency of discussions about problems between the participants and their friends supports the well-documented finding that adolescents tend to rely on their peers for help with problems (Evans et al., 2005; Leavey et al., 2011; Pisani et al., 2012).

Of the options provided in the questionnaire, participants received peer disclosures of problems about school most often, followed by friendship problems. Mental and physical health were most likely to be discussed rarely. Family problems were sometimes discussed. The most frequently listed "Other" topics which had not been provided in the questionnaire were relationships and

bullying. These findings demonstrate that adolescents seek help from peers for a wide range of personal problems. Disclosures of problems relating to mental illness dominate the literature on help-seeking in adolescence (e.g. Clement et al., 2015; Gulliver et al., 2010; Nearchou et al., 2018). However, mental health was one of the least regularly discussed topics in this study. This finding justifies the expansion of research on help-seeking into domains other than mental health, to better reflect the range of problems discussed between adolescent peers.

There were significant differences in the frequency with which males and females discussed topics relating to friendships, family, mental health, and "Other" problems, with females reporting that they discuss these issues with friends more often than males. This finding is relevant to literature showing that males, or those identifying more closely with masculine norms, are less likely to deal with personal problems by approaching others (Herres, 2015; Kessels & Steinmayr, 2013; Sears et al., 2009), and that males may have more difficulty showing vulnerability within friendship groups (Goede et al., 2009). However, a unique aspect of this study was the exploration of adolescent help-seeking from the perspective of the friend from whom help is sought. It did not examine male and female patterns of help-seeking; rather, it explored the frequency with which adolescents received disclosures of friends' problems. This research therefore demonstrated that females are more likely than males to receive disclosures of friends' personal problems. It is possible that females were also providing support to male friends. Indeed, a Canadian study found that a sample of adolescent males in rural communities reported higher intentions of seeking help from female friends than male friends, possibly because they also perceived female friends as more supportive (Sears et al., 2009). Whilst the majority of adolescent friendships are same-sex, there is a lack of research investigating cross-sex friendships in adolescence (Poulin & Chan, 2010).

Participants were asked to give a problem which had been difficult to support a friend with. The most common response (30% of respondents) was problems with home life and family. Byrne et al. (2015) found that a sample of school-aged adolescents scored highest on indicators of stress relating to "home life", compared to other adolescent stressors, including "school performance" and "romantic relationships." The current study demonstrated that as well as being a

cause of stress, home life is also an area with which adolescents struggle to support their friends.

The next most common response was depression, self-harm, or suicidal thoughts (15% of male and 23% of female respondents). Other difficult problems included relationships, friendship issues, bereavement and serious illness, and bullying. A higher proportion of male than female respondents listed bullying as a difficult problem (9% and 2% respectively). This finding demonstrates the relevance of the vignettes in this study to problems with which adolescents support their friends. However, it also demonstrates the importance of examining the phenomenon of peer support for other problems, particularly relating to home life and family.

5.2 How Disclosures Are Made (RQ1.1c)

Key findings.

- Male participants were more likely than females to have friends disclose personal problems using technology more frequently than face-to-face.
- 79% of participants had received a disclosure of a friend's personal problem on social media. 49% of participants had seen a disclosure of a personal problem via a public post. Females were more likely than males to have received disclosures on social media.
- Snapchat was the most popular website for disclosures of personal problems.
- Some male respondents (7%) had received a disclosure of a friend's problem while gaming online.

Analysis.

Help-seeking online may be qualitatively different to face-to-face help-seeking (Frison & Eggermont, 2015), and young people consider talking online to be different from "real-life" interactions (Gray, 2018). This may be partly due to the online disinhibition effect, causing people to act differently online (Suler, 2004). The current study demonstrated that adolescents experience both types of help-seeking from friends. There is therefore justification for research differentiating between help-seeking online and face-to-face.

There was a significant difference between how males and females reported that their friends share problems. Female participants' friends were more likely to disclose problems face-to-face, while male participants' friends were more likely to use technology. A study of Australian adolescents aged 15-19 found that males showed a preference for help-seeking online (Bradford & Rickwood, 2014). Unlike the current study, it examined formal help-seeking from professionals rather than informal help-seeking from friends, and concerned help-seeking rather than help-giving. If it is assumed that the male participants in the current study were more likely to receive disclosures from male than female peers, the findings suggest a pattern in males preferring to have such discussions online. Research into online help-seeking may therefore be particularly relevant to adolescent males. Research has shown that males are less likely to seek support for personal problems (Herres, 2015; Kessels & Steinmayr, 2013; Sears et al., 2009); online platforms may provide avenues to encourage males to seek help from friends.

Three quarters of participants (78%) had experienced a disclosure of a friend's problem on social media. More females than males reported primarily face-to-face disclosures of personal problems, yet more females than males also reported having received disclosures on social media. This can be explained by the finding that females discuss problems with friends more frequently overall. It is likely that females experience more face-to-face and more online disclosures than males.

Snapchat and Instagram were the most frequently listed websites for receiving disclosures of a friend's personal problem. Recent literature on young people's use of social media in the UK has found Facebook to be the most frequently used platform (Court, 2016; Gray, 2018). The relative popularity of Snapchat and Instagram in the current study may reflect: the fast-changing nature of social media use among young people, geographical and demographic differences in the samples, or that Snapchat and Instagram are preferred specifically for problem-sharing. The latter proposal should be explored further, as the nature of disclosures on different social media platforms may vary. Two participants noted on their questionnaires that Snapchat is their friends' preferred platform for discussing problems, as messages disappear once they have been read.

Exploring the nature of self-disclosure on specific social media platforms may therefore have useful contributions to make to this field.

No female respondents and 7% of male respondents reported receiving a peer's disclosure while gaming. This is consistent with Ofcom's (2019) finding that on average, boys aged 12-15 in the UK spend almost double the amount of time gaming than girls of the same age. The study also found that gaming has a strong social element: 58% of gamers aged 12-15 use online chat features within the game. The current study showed that for adolescent males, these online gaming discussions may include disclosures of personal problems.

5.3 Responses to a Serious Problem (RQ1.2)

Key findings.

- Participants showed less concern for the character with anxiety than for those experiencing depression or self-harm.
- Most participants responded positively to the characters' disclosures of problems relating to mental illness, but some gave unhelpful responses.
- Two thirds of participants encouraged the characters to tell an adult about their problem.
- Half of participants asked the friends experiencing depression and self-harm if they had considered suicide.
- There was no significant gender difference in whether participants took action based on the character's disclosure, with or without permission.
- Participants were more likely to act without the character's permission if he/she was self-harming than if he/she was experiencing depression or anxiety.
- The most common reported intended action was to tell an adult. Family members and school staff were the most frequently specified adults.

Analysis: thoughts and words.

Unlike previous research examining whether adolescents can correctly identify mental illnesses in peers (Burns & Rapee, 2006; Coles et al., 2016; Marshall &

Dunstan, 2013), this study explored adolescents' thoughts, words, and actions in response to a friend's disclosure of a problem relating to mental illness.

Participants were likely to worry about the friend in each vignette and to think that she/he had a serious problem. The character experiencing anxiety elicited least concern: 38% of respondents thought it was a serious problem, compared to 69% in response to depression and 76% to self-harm. Similarly, a study of Australian adolescents' MHFA intentions found that participants provided a higher quality of responses to the depression than to the anxiety vignette, and were less likely to recognise the type of disorder experienced by the anxiety-vignette character (Mason et al., 2015). The finding of the current study is notable as anxiety disorders are more common than depressive disorders among children and adolescents in England (Sadler, Vizard, Ford, Marcheselli, et al., 2018). One concerning interpretation is that the participants in the current study were more accustomed to friends experiencing such difficulties and therefore considered it a less serious problem.

Most participants responded to the vignette-characters with kindness and understanding. Participants were likely to tell the character that they were worried about them and to reassure them of their friendship. These responses were most frequently given to the depression vignette (64% and 63% respectively), followed by the self-harm (61% and 60%) then the anxiety vignette (51% and 49%). These responses to a friend's disclosure of a mental health problem were endorsed in Ross et al.'s (2012) Delphi study: The consulted professionals reported that it is important to be a good friend and not to stigmatise.

Another positive response is to encourage the friend to involve an adult (Ross et al., 2012). Over 60% of respondents to each vignette stated that they would encourage the character to tell an adult. This is consistent with a similar study in which over 40% of respondents did not report that they would encourage a vignette-character with depression to connect with an adult; the authors considered this finding disappointing (Mason et al., 2015). Byrne et al. (2015) found similarly low rates of adolescents encouraging vignette-characters experiencing depression vignettes to involve an adult.

Ross et al. (2012) found that it is important for friends to know how to respond in a crisis, including asking whether the friend had considered suicide. In Yap et al.'s (2011) study of adolescents' MHFA actions, 38% queried suicide in response

to a friend's mental health problems; none of the participants in Byrne et al.'s (2015) study took this action, probably because participants were not given multiple-choice options. In the current study, around half of the participants reported that they would ask the characters experiencing depression and self-harm if they had considered suicide (47% and 50% respectively).

A small number of participants (more males than females) gave stigmatising reactions to the anxiety and self-harm vignettes. Stigma is a major barrier to help-seeking for mental illness (Clement et al., 2015; Gulliver et al., 2010); it comprises ignorance, prejudice, and discrimination (Thornicroft, Rose, Kassam, & Sartorius, 2007). Prejudice was evident when participants made negative comments (4% of male respondents) or discouraged the friend from the negatively perceived activity (7-8% of male respondents). The negatively perceived activities were the act of cutting (self-harm) and missing school due to anxiety. Professionals have recommended that adolescents responding to a disclosure should be non-judgemental and avoid blaming the individual (Ross et al., 2012). Stigmatising responses were less common in the current study than in previous similar studies, however; Yap et al. (2011) found that 45% of participants had told a friend or family member experiencing a mental illness to "get their act together."

The self-harm vignette-character had posted the problem publicly online. Previous research has suggested that online self-disclosures may be received negatively (Radovic et al., 2017). However, negative perceptions of the character's online disclosure were not evident in the current study: There were no comments about the online nature of the character's disclosure. This may be because such disclosures were perceived as normal: 49% of participants had received a disclosure of a friend's problem publicly online. Radovic et al.'s (2017) study also used a sample of 23 clinically depressed adolescent participants, with ages ranging from 13 to 20 (mean 16). This difference in sample may also explain why participants of the current study did not respond negatively to the online disclosure.

Almost double the number of females than males reported that they would encourage the characters experiencing depression and self-harm to tell them more about the problem. This is consistent with the finding in Section 5.1 that females discuss problems with friends more frequently than males. Previous research found that adolescent females perceived emotional problems in a

vignette as more severe than adolescent males (Raviv et al., 2009). In the current study, more females than males thought that the characters were experiencing serious problems, but not by large margins: 25% more females than males responded in this way to the depression vignette, 16% in response to self-harm, and 9% to anxiety. There were few other gender differences in participants' thoughts and verbal responses to the vignettes.

Analysis: actions.

Participants were likely to report that they would take action in response to all three vignettes. For the vignettes containing depression and anxiety, the most common response was to act with the character's permission (48% and 53% respectively). When the character was self-harming, the most common response was to act without permission (51%). The fear of confidentiality being broken is a barrier to adolescents seeking help from professionals (Clement et al., 2015). This finding shows that friends would also consider breaking confidentiality following a disclosure of self-harm.

It is unclear why participants were more likely to act without permission in response to the self-harm vignette than to the others. Similar proportions of participants perceived depression and self-harm as serious problems, suggesting that the decision to act was not necessarily based on this perception (although the questionnaire did not allow for comparison of levels of perceived severity across the vignettes). The perception that the problem could get worse was also similar for the self-harm and depression vignettes, suggesting that this did not factor into the decision either. There is a need for research into what factors prompt adolescents to act in response to a peer's problem, with or without permission.

The vignette-characters in this study were not directly asking for help; they were engaging in self-disclosure by exposing personal and intimate information (Misoch, 2015). This study supports the idea that self-disclosure is a form of informal help-seeking: It demonstrated that self-disclosure to a peer is likely to lead to the provision of help in the form of emotional support and sometimes support from other sources.

In this study, the most common intended action was to tell someone about the character's problem. When participants specified whom they would tell, "family members" was the most common response (16% of respondents). In studies about adolescent help-seeking, family members (usually parents) are common sources of support (Evans et al., 2005; Fortune et al., 2008; Leavey et al., 2011; Lindley et al., 2019). A developmental task of adolescence is to achieve emotional independence from parents (Nurmi, 2004). The findings of this and previous studies demonstrate that while seeking emotional independence, adolescents still rely on their parents for support. "School staff" was the second most common response (11% of respondents); this is consistent with previous studies (Evans, et al., 2005; Fortune et al., 2008; Leavey et al., 2011). The current study explored whom adolescents would tell about a friend's problem, rather than their own problem. The findings suggest that adolescents use similar sources of support for friends' problems as they would use for their own problems.

There was no significant gender difference in whether or not participants chose to act with or without the friend's permission. This finding contradicts a previous study which found that adolescent girls showed greater willingness than boys to seek help for someone experiencing an emotional problem (Raviv et al., 2009). There were some gender differences regarding whom participants would tell about the friend's problem. Twice as many females as males intended to tell school staff or family members about the character's depression, and twice as many males as females intended to tell a family member about the character's self-harm. Although the response was not very popular, males were also more likely than females to talk to a professional about the friend's problem across all three vignettes. However due to low code frequencies, the generalisability of these gender differences is limited.

5.4 Confidence in Responding to a Serious Problem (RQ1.3)

Key findings.

- Participants were moderately confident in responding to a peer disclosing a serious personal problem relating to mental illness.
- Males were significantly more confident than females in responding to the character's disclosure of depression.

- Participants showed relatively equal levels of confidence in replying and taking action to the problems in all three vignettes.

Analysis.

Participants were asked how confident they felt on a scale of 0 (*not at all confident*) to 10 (*very confident*) that they had said and done the right things in response to the vignettes: Average answers converged around 6 and 7, demonstrating moderate confidence across all three vignettes for both genders. On average, participants were slightly more confident in the actions they had taken than in the things that they had said in response to the vignettes.

Across all three vignettes, males were more confident than females that they had given the right verbal response and taken the right action. There was a statistically significant gender difference for the depression vignette only. Males were least confident in responding to the anxiety vignette, while females were least confident responding to the depression vignette. However, the margins were small. The literature search did not identify any studies on MHL and MHFA which measured adolescents' confidence in helping peers with problems relating to mental illness.

6. Phase 2 Findings and Discussion

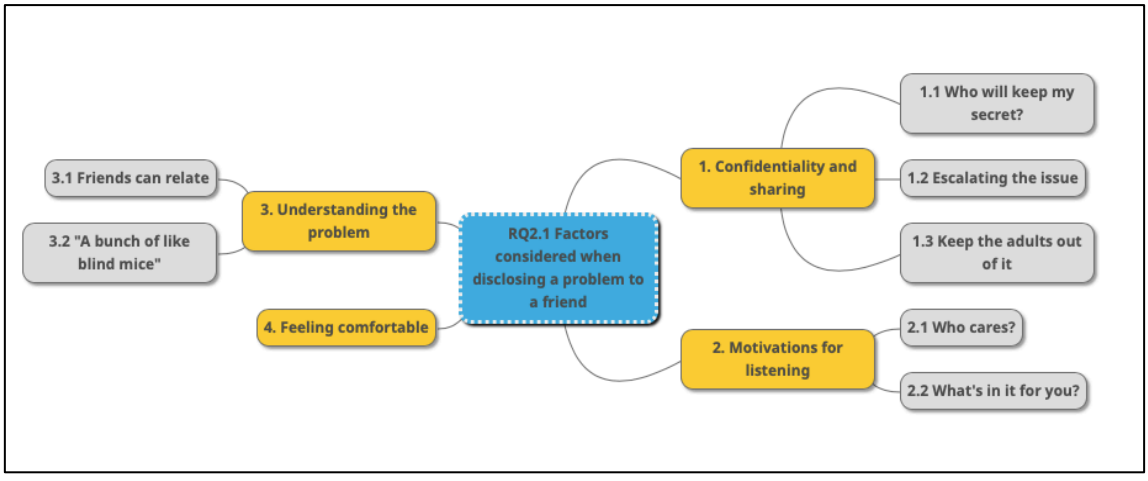
The Phase 2 findings and discussion are structured by RQ. Links between findings for each RQ are highlighted throughout and in Section 7.1. The process of thematic analysis is described in Section 3.7, with worked examples in Appendices M-P. Throughout this report, quotations are not labelled with the focus group from which they were taken, to protect participants' anonymity. I ensured that as even a number of quotations as possible were used from each focus group.

6.1 Factors Considered When Disclosing a Problem (RQ2.1)

Summary.

In answer to RQ2.1, four themes were identified. An overview of the themes and subthemes are shown in Figure 33, then summarised briefly below.

Figure 33
Themes and subthemes relating to RQ2.1



1. Confidentiality and sharing.

When deciding whom to tell about problems, all groups raised confidentiality and sharing. They considered whether the potential listener would be likely to share their problem, with whom, and the possible consequences. Participants had varying degrees of trust for adults, and had mixed feelings about whether adult involvement should be avoided.

2. Motivations for listening.

Participants were concerned about the disclosee's motivations for listening to their problem. They considered who would care about their problems and whether the listener might have an ulterior motive for hearing their secrets.

3. Understanding the problem.

Participants considered who would have the best understanding of the problem and therefore be able to help them most effectively. There were mixed views regarding whether friends' familiarity with the problem or adults' knowledge and experience would lead to more effective support.

4. Feeling comfortable.

Participants usually felt more comfortable disclosing problems to friends than to adults, who were sometimes considered intimidating. Friends were also more available than adults to listen to problems.

The themes and subthemes for RQ2.1 will now be described in detail and related to relevant literature.

Theme 1 Confidentiality and sharing.

Subtheme 1.1 Who will keep my secret?

When considering with whom to share their problem, participants were concerned about confidentiality. There was disagreement over whether friends or adults were more likely to keep a problem confidential: One participant stated that she trusted her best friend with her life, while another noted that "you never know what [friends] will do with [the secret] after, like if you fall out." This is a legitimate concern since peer victimisation in adolescence tends to be characterised by relational aggression such as spreading rumours (Troop-Gordon, 2017). Particularly in the sometimes unstable context of adolescent friendships (Poulin & Chan, 2010), disclosing secrets to a best friend may provide ammunition for future victimisation if the friendship ends. In most groups, however, it was felt that friends were more reliable than adults in respecting confidentiality: "Like the

teacher, depends what it is, they could tell someone. Like a friend would be more likely not to tell someone."

In this context, participants were considering whom they would tell about any problem. Confidentiality concerns are also a barrier to help-seeking from professionals for mental illness (Clement et al., 2015; Corry & Leavey, 2017). Leavey et al.'s (2011) study with adolescents in the UK about help-seeking from a GP found that issues of privacy and confidentiality were the strongest area of consensus among the participants. The current study showed that these concerns extend to adolescents disclosing personal problems to any potential source of support.

The view that friends are more likely to keep a secret than adults is also consistent with literature on adolescent peer relationships. Adolescence is a period in which trust becomes increasingly important in friendships (Brown, 2004) and sharing secrets may provide social benefits such as increased intimacy with the disclosee (Frijns et al., 2013). Throughout adolescence, young people disclose less to parents and more to friends (Solis et al., 2015). The importance of trust in adolescent friendships (highlighted in this study) may be responsible for adolescents' preference for sharing difficulties with friends (as shown in Evans et al., 2005; Leavey et al., 2011; Pisani et al., 2012; Reichardt, 2016).

Subtheme 1.2 Escalating the issue.

Participants were concerned that sharing the problem could result in unwanted escalation. It was felt that if adolescents confided in an adult, the adult was likely to escalate the problem further: "The adult will probably just pass it on to somebody else so they can pass it on to probably like ChildLine or something like the social services." Similarly, Klineberg et al. (2013) found that adolescents who had self-harmed did not trust school staff, because they were perceived as likely to share the disclosure. The current findings suggested that this concern is also relevant for disclosures of other personal problems.

It was acknowledged that a friend might sometimes need to break confidentiality by telling an adult, particularly if the problem was too difficult for the friend to handle. Some participants positioned escalation to adults as a useful back-up for friends:

> Then if [friends] think it's like an issue or like too much to have on their back or something, they can like always pass it on to like their family and see what they should do about it, because it might be too much for them to handle.

Others felt that it was an important responsibility:

> [If a friend tells you a serious problem] you should tell someone quickly before that problem gets too much for them to handle, and for the people involved to handle, and then when people ask, "Why didn't you say anything earlier?" you just stare at them blankly.

In the above quotation, the participant recognises that guilt and self-blame can occur when receiving a disclosure of a serious problem from a friend. Reichardt (2016) found that adolescents receiving disclosures of self-harm can experience guilt, responsibility, and shame. The current study showed that adolescents recognise this risk with regards to other problems, and believe that passing the problem onto an adult may help to alleviate self-blame.

Overall, there were mixed feelings over whether escalation was something to be avoided or an important way to help a friend with a serious problem. This conflict can be conceptualised using the framework of *prosocial risk-taking*, in which an action taken to benefit another individual incurs a cost in the form of risk (Do, Guassi Moreira, & Telzer, 2017). This is a recent area of study, which takes a positive approach to the phenomenon of increased risk-taking in adolescence. Adolescents who escalate a friend's problem by passing it onto an adult are taking a prosocial risk, as their desire to help their friend could cost them the trust which is integral to adolescent friendships. This helps to explain the conflict that the participants experienced in this area.

Subtheme 1.3 Keep the adults out of it.

Throughout the narrative of one group, adults were positioned as enemies who should be kept out of problems between young people. It was felt that telling adults constituted "snitching" and could worsen the situation:

> Yeah if you add the other people then they'd get caught and the bullies get pressured by the teachers, and then that bullied kid becomes a snitch. Like the bully's in isolation for the day or something and the rest of his mates have gone to that bullied kid and it just passes around. It's really not necessary.

Another group felt that adults should not be involved in adolescents' problems, because they are old enough to "be taking care of ourselves." These views were also raised in Boulton, Boulton, Down, Sanders, and Craddock's (2017) UK-based study about barriers to adolescents seeking help from teachers for bullying: The participants felt that telling teachers could make them feel weak and lead to peer disapproval.

Theme 2 Motivations for listening.

Subtheme 2.1 Who cares?

Participants were concerned about who would care about their problem. Adults (particularly school staff) were generally discussed negatively in this context: Teachers "might say they care but, they might care a little bit but they don't actually care." Teachers were considered less likely than a peer to take the problem seriously: "A teacher might just say that you're being dramatic or something, but a friend would kind of listen to that and probably help you a bit more." The perception that school staff would not be supportive of problems has been found to correlate with negative attitudes towards help-seeking from an adult for bullying and threats of violence (Eliot et al., 2010). The current study demonstrated that this perception might also prompt adolescents to disclose personal problems to a peer rather than to an adult.

Whilst friends were perceived as caring more than adults, some participants believed that their friends may not take their problems seriously either. There was a risk that friends would treat the problem as a joke or tease them for it: "You're in there kind of joking, when it's not a joke to you, like that in front of your mates and then everyone's like, 'Ooh what're you on about?'" This dismissal of a friend's problem may be related to stigma, which comprises ignorance, prejudice (attitudes) and discrimination (behaviour; Thornicroft et al., 2007). Measures of stigma in existing research have included stigmatising attitudes and actions (e.g. Mason et al., 2015). However, treating problems as a joke can be interpreted as a form of discrimination through avoidance, in which problems are brushed off because they are viewed as uncomfortable. Such treatment may be particularly distressing within the context of male adolescent friendships; young men may avoid situations in which they could be perceived as vulnerable, as this could threaten their power and status within the friendship group (Goede et al., 2009).

Stigma is a commonly cited barrier to help-seeking for mental illness (Clement et al., 2015; Gulliver et al., 2010); the findings of the current study suggested that stigma may also be a barrier to adolescents discussing other problems with peers.

Subtheme 2.2 What's in it for you?

Participants considered individuals' motivations for listening to their problem. In two groups, participants were suspicious of adults' motivations. They felt that teachers in particular "just really wanna know more about what's happening in the school, so using that person instead of actually listening to that person." The perception that teachers might want gossip about students' lives was not found in existing literature on adolescent help-seeking. Lack of trust was a barrier to self-harming adolescents seeking help from school staff (Klineberg et al., 2013); however, this was not explored beyond the likelihood of teachers breaking confidentiality. The current study raised a different element of mistrust: suspicions about adults' motivations for listening to the disclosure.

In one group, wanting to "know your business" was also raised as a possible motivation for friends listening to problems. Parents, however, were seen as having no ulterior motives when listening to problems: "So if you like just tell your parents and just say like, 'What should I do?' and they'll, they'll always do the best for you." Family members are common sources of support for adolescents, though often secondary to friends (Evans et al., 2005; Fortune et al., 2008; Leavey et al., 2011). This study demonstrated that parents may be viewed as more trustworthy than other adults because they are perceived as being motivated by wanting the best for their child.

Theme 3 Understanding the problem.

Subtheme 3.1 Friends can relate.

Participants felt that friends were likely to understand their problems. Peers were more likely than adults to have specific knowledge relating to their problem, as "there's some subjects that your parents or teachers might not even know about." Friends were more likely to understand each other's problems as they are close in age and may have had similar experiences: "Sometimes people feel a bit more

comfortable around other people their age, because, because like their emotions will probably be the same so they can trust them to understand."

Some participants felt that their friends knew them better than anyone and therefore "they know how to deal with your situation, like personalised to you." This finding suggested that adolescents' ability to relate to friends' problems incentivises disclosure to peers rather than adults.

Subtheme 3.2 "A bunch of like blind mice."

Whilst friends were seen as more able to relate to adolescents' problems, participants felt that seeking help from adults was more appropriate for serious problems: "I'll talk to [*sic*] more bigger things with my mum and more smaller things with my friends." However, participants disagreed over whether adults know how to deal with adolescents' problems:

> Participant A: Basically yeah, if you get help from like an adult, if it's more on the extreme side they might know what's going on.
>
> Researcher: Mm. Anyone agree or disagree with that?
>
> Participant B: I disagree. I don't think they know everything.

Others felt that going to friends might be unhelpful due to their inexperience: "My dad once told me that friends can be just as inexperienced as you are in that problem, so you're just like a bunch of like blind mice trying to lead each other."

The perceived effectiveness of adult help is an established barrier to adolescent help-seeking. Adolescents who self-harm have been found to believe that adults have limited capacity to help them (Fortune et al., 2008; Reichardt, 2016). In a systematic review of barriers and facilitators to adolescent help-seeking for mental illness, Gulliver et al. (2010) found just one study which listed concern about people having the skills to cope with the problem as a barrier. However, the current study involved lengthy debates about who could offer the most effective support. This may be because it concerned disclosures of any personal problem, rather than mental illness specifically.

Theme 4 Feeling comfortable.

Participants often stated that they felt most comfortable discussing problems with their friends: "I find it easier to open up to my friends than like my family or

something like that." This is consistent with the finding that friends were able to relate to problems (Subtheme 3.1), but also captures the unique emotional closeness between peers at this stage of life. A developmental task of adolescence is to achieve emotional independence from parents (Nurmi, 2004); the increased importance of peers may be due to adolescents relying on peers to fill the void left by emotional autonomy from parents (Steinberg & Monahan, 2007). In the current study, some participants felt that their friends were a better source of emotional comfort than their families, which is consistent with this developmental theory.

Disclosing problems to adults was sometimes considered intimidating, as adults might judge or stigmatise the adolescent based on their problem:

> [Teachers] might treat you differently then, if you tell them like how things are really happening. Like if something happened at home and you told them, they'll probably be like, "Oh they're a problematic child," or "They've got a bad family," things like that.

Gulliver et al. (2010) found that the most prominent barrier to young people seeking help for mental illness was the perception that potential helpers would have a stigmatising response. This is reflected in the current study, which demonstrated that the effect of stigmatising attitudes on help-seeking behaviours can extend beyond mental illness to other types of personal problem, such as problems at home.

On a pragmatic note, friends were sometimes seen as more physically available to speak to than adults, as they have more time to discuss problems and give advice: "Maybe it's like sometimes better to just go to your friends because you might get more out of them."

Key findings.

The participants took the following factors into account when considering whether or not to disclose a problem to a friend:

- Who is most likely to keep the problem confidential?
- Who is less likely to escalate the issue by passing it onto other people?
- Will my friend be able to cope with the problem alone?
- Should I deal with this problem without involving adults?
- Who cares about my problem?

- What are the person's motives for listening to my problem?
- Who will be able to relate to my problem?
- Who will be able to provide me with effective support?
- Who am I most comfortable speaking to?
- Who is available to speak to?

6.2 Views on School-Based PSIs (RQ2.2)

To answer RQ2.2, participants were presented with three types of PSI. The descriptions of each PSI-type that were given to the focus groups are outlined below. Stick-figure drawings were also used to illustrate each example (Appendix D).

- Organised PSI: A system set up and overseen by an adult at school, for pupils to help each other with problems, such as a buddy system.
- Online PSI: An online system set up and overseen by an adult at school, for pupils to help each other with problems, such as an online forum where pupils post problems, and other pupils respond to offer advice. It is a type of organised PSI, which is run online.
- Universal PSI: A system in which all pupils are given instruction by an adult at school on how to improve the support that they give to their friends, such as how to listen and when to involve an adult. When friends discuss problems, they can then use this information to support their friend effectively.

PSI-type matrices.

Participants' discussions about each PSI-type were analysed to elicit views about what makes an effective school-based PSI. To prompt further discussion of each PSI-type, participants were asked to draw a symbol for each PSI-type on a matrix, to rate its popularity and helpfulness. Their answers were converted into graphs (Figures 34-36) on a popularity scale from 0 (*nobody would use it*) to 20 (*lots of people would use it*) and on a helpfulness scale from 0 (*not at all helpful*) to 20 (*very helpful*). Each dot marks one participant's positioning of the PSI-type on the matrix.

Figure 34

Perceived popularity and helpfulness of organised PSIs

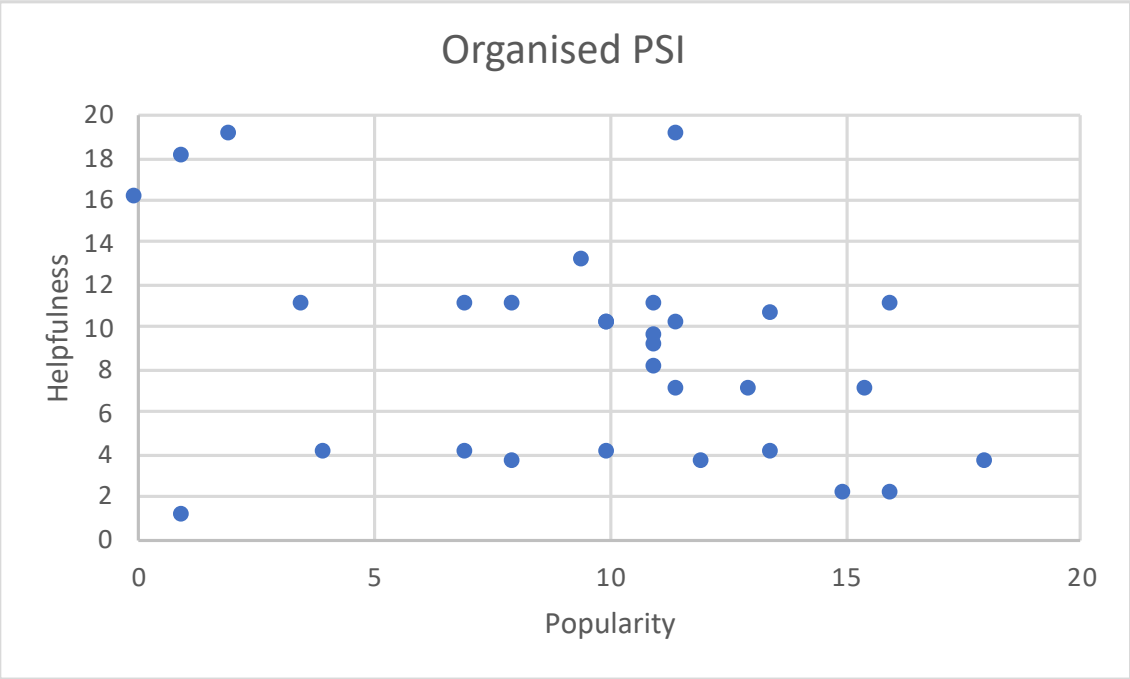


Figure 35

Perceived popularity and helpfulness of online PSIs

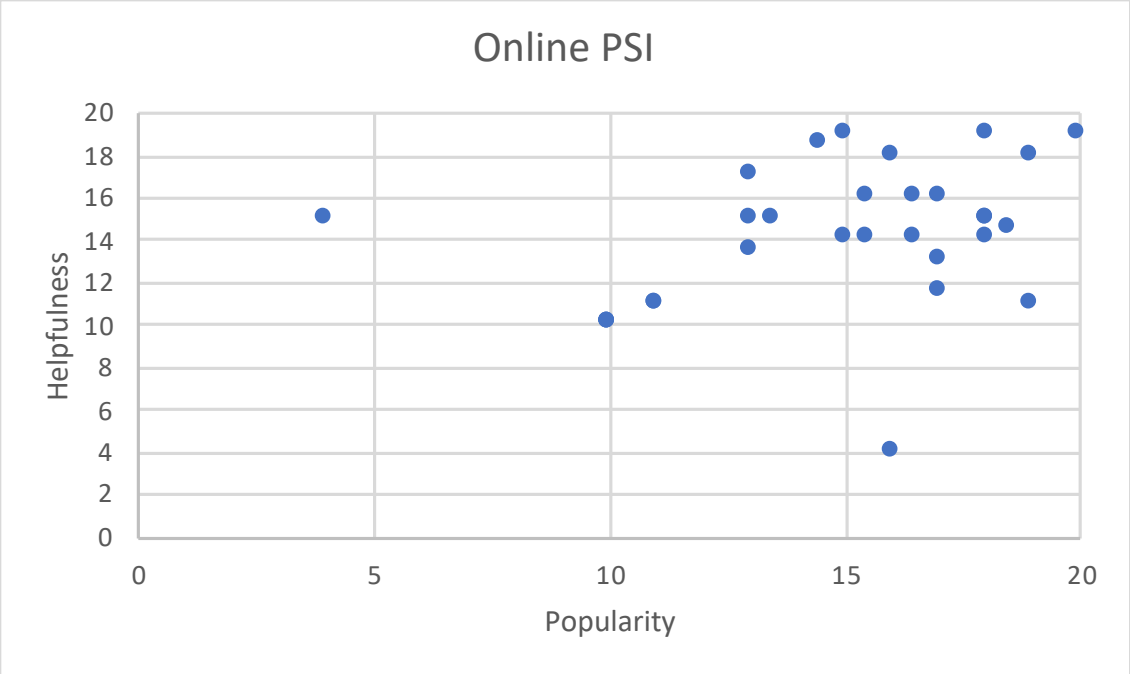
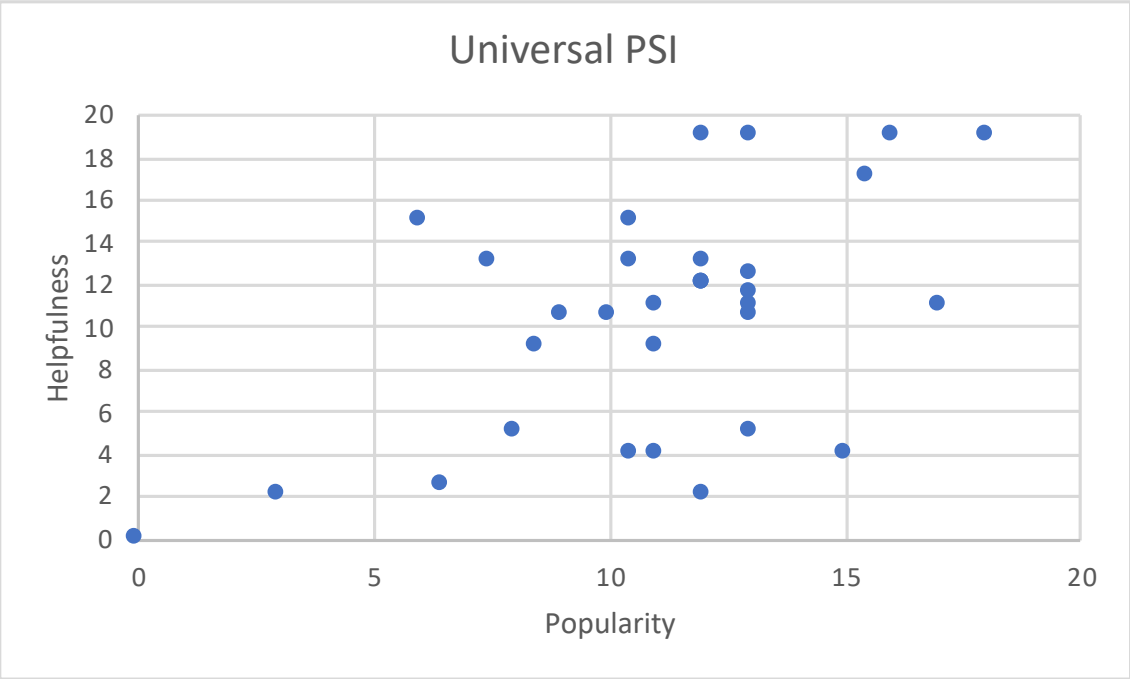


Figure 36

Perceived popularity and helpfulness of universal PSIs

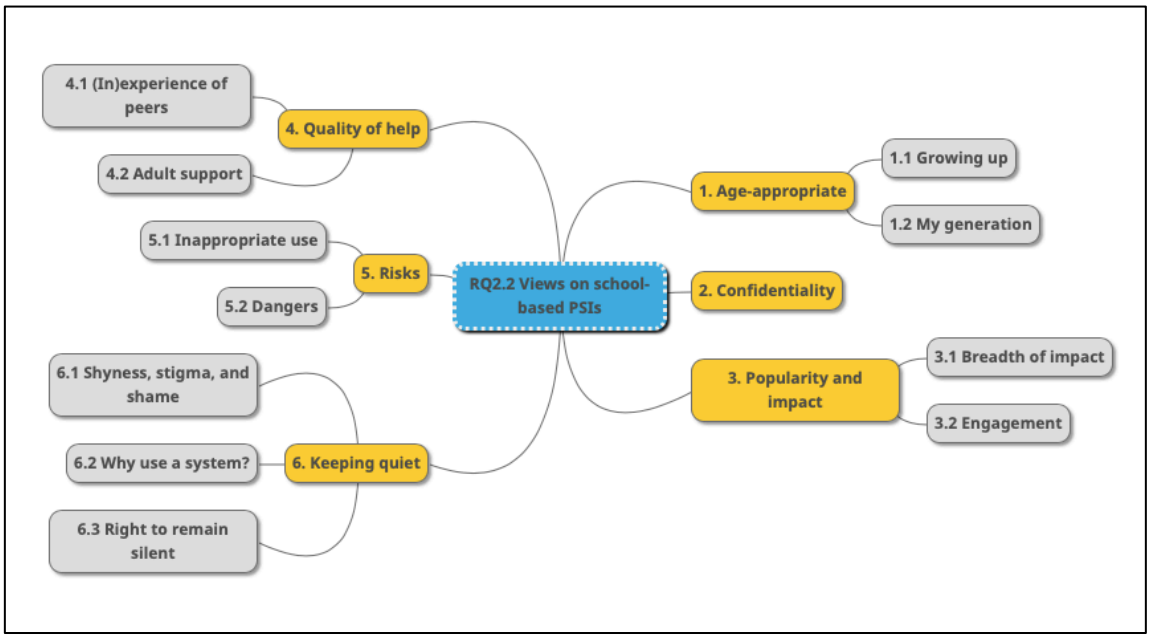


Figures 34-36 show that participants' views on the universal and organised PSIs were broad-ranging. The universal PSI was viewed as slightly more popular and helpful than the organised PSI. The online PSI, however, was clearly perceived as more popular and helpful than the other two PSI-types. This was reflected in the participants' discussions within the focus groups.

Summary.

In answer to RQ2.2, six themes were identified. An overview of the themes and subthemes are shown in Figure 37, then summarised briefly below.

Figure 37
Themes and subthemes relating to RQ2.2



1. Age-appropriate.

It was important to participants that PSIs are appropriate for their age: both the chronological age of adolescence and the "age" in which they saw themselves as living.

2. Confidentiality.

Participants were concerned about whether a PSI would be confidential. They considered the trustworthiness of the disclosee and the security of the system.

3. Popularity and impact.

Participants discussed the potential impact of each PSI-type, including how many people would benefit from each system. The impact of each PSI-type was considered dependent on how successfully it engaged pupils.

4. Quality of help.

Participants considered the quality of help provided within each PSI-type. They felt it was important for the helpers to have experience of the problem, in order to offer high-quality support. Adults were perceived as offering better quality support than peers for serious problems.

5. Risks.

Participants considered the risks involved with each PSI-type. One risk was that pupils may not use the systems appropriately. Other dangers were identified, such as cyber-bullying or people becoming distressed by the content of the universal PSI.

6. Keeping quiet.

Some participants discussed the not-sharing of problems due to low confidence, stigma about sharing problems, or shame about using school-based systems instead of "real friends." Participants also noted that some people prefer not to share problems and that this should be respected.

The themes and subthemes for RQ2.2 will now be described in detail and related to relevant literature.

Theme 1 Age-appropriate.

Subtheme 1.1 Growing up.

Participants made a striking number of references to the "massive wave" of changes that took place when they reached secondary school. Their descriptions of growing up suggested implicit nostalgia for the simpler days of primary school, when there was less peer pressure and fewer defined social standards:

> In primary school, it's diff- a lot different, because there isn't all like these social standards between people, you either have to be funny or you have to be mean, you have to be rude, whereas in primary school it's a lot calmer.

Participants felt that at secondary school, there was also more cruelty between peers: "In secondary school like there's people in here that don't care about other

people's feelings and stuff, recognise you, no one cares about like what you're saying."

Evidence from neuroimaging and behavioural studies show that relationships and social networks become increasingly important in adolescence (Blakemore & Mills, 2014). Adolescents are more sensitive to peer evaluation and social standing than children and adults (Somerville, 2013); the participants in this study raised the negative outcomes of this increased sensitivity. Steinberg and Monahan (2007) found that susceptibility to peer influence increased between the ages of 10 and 14, which is consistent with these 13-14 year-old participants' view that negative experiences relating to peer expectations had increased since their time at primary school. This finding highlights the need for the design and review of PSIs to be tailored to secondary school pupils; PSIs that are effective in primary school may not transfer successfully to the adolescent context.

Several groups felt that PSIs would be less popular in secondary schools than in primary schools. One reason was that adolescents "want to like be brave" and therefore prefer to handle problems on their own. This relates to the finding that some participants preferred to keep adults out of their problems (RQ2.1 Subtheme 1.3). However, the finding that some adolescents preferred not to share problems with anyone challenges the idea that adolescents rely on their peers for emotional support, in the absence of parental support (Steinberg & Monahan, 2007). Individual differences in participants' willingness to share personal problems were evident throughout the current study.

Due to the social changes in adolescence, participants considered it important that PSIs "drop all the kiddie stuff" to be appropriate for their age group. Participants in all but one of the groups criticised organised PSIs for being too childish to be taken seriously at secondary school.

Subtheme 1.2 My generation.

Participants wanted PSIs to take into account what they perceived as the unique features of their generation, such as being technologically literate. PSIs that took advantage of this (i.e. online PSIs) were considered most appropriate: "I think [online PSIs] would be better for our generation because we're used to like technology basically."

Online PSIs were also positively viewed as avoiding the awkwardness that people of their generation experience when disclosing problems face-to-face: “It’s just easier when you’re behind, you’re behind the screen, and they can’t see you, see what you’re, emotion you’re showing at the time.” This finding is consistent with Suler’s (2004) theory of the benign online disinhibition effect, in which people find it easier to share personal information online than in person. This effect could be employed to encourage pupils to seek support for personal problems using an online PSI.

There was some disagreement, however, about whether adolescents should be encouraged to develop interpersonal skills by disclosing problems face-to-face: “Basically people should like be able to talk to like other people, . . . like you’ve got a voice for a reason, you need to use it.” The debate over the advantages and disadvantages of online interactions is reflected in academic literature. There are concerns that adolescents develop shallow relationships online, but also recognition of the opportunities that the internet affords to develop meaningful relationships (Valkenburg & Peter, 2011). Participants in the current study engaged in this debate, with strong opinions on both sides regarding the benefits and downsides of their generation discussing problems online.

Some participants felt that their generation had a better understanding of mental health: “Especially like older generations of adults, because especially when they can sometimes get stuck in a kind of time zone where the sort of mental health is a bad thing.” I found no published literature comparing levels of mental health literacy or stigma in adolescents and adults in the UK. However, research has shown that in England, public attitudes to people with diagnosable mental illnesses improved between 2008 and 2014, and that people aged 16-34 had fewer stigmatising attitudes than those aged 55+ (TNS BMRB, 2015). This study did not include people younger than sixteen and its youngest age category was very broad. It can therefore offer only speculative insight as to whether the participants’ perceptions that their generation had a better understanding of mental health is reflected in empirical research.

Perhaps due to this belief, some participants were bored of the topic of mental health and felt that they had heard too much about it. This was a criticism of the universal PSI, which might fail to engage a generation who have “done this so many times.” Poor MHL has been identified as a barrier to adolescents seeking

help with mental health problems (Gulliver et al., 2010), and the quality of adolescents' MHL outside the UK has been questioned (Byrne et al., 2015; Mason et al., 2015). The adolescents in the current study considered themselves to have high MHL already. This perceived high MHL seemed to reduce the likelihood of adolescents engaging with material on the subject, including the content of a universal PSI.

One group felt that their generation was unfairly described as "selfish" and that they "only go on their phones." They emphasised the importance of adults seeking and respecting their views:

> And they're sitting there talking about, "Oh yeah kids think this." Like get your proof before you go and say it on live national TV, because like I don't think kids really get recognised that much in their opinion and thoughts.

This was a poignant comment in the context of this study, which was partly motivated by the lack of pupils' views on school-based PSIs in existing literature.

Theme 2 Confidentiality.

The confidentiality of each PSI-type was a major concern for all groups. The findings in RQ2.1 Subtheme 1.1 showed that adolescents disclose problems to people whom they trust. This finding evidently extends to the use of structured systems such as organised and online PSIs. The importance of confidentiality is consistent with findings from research gaining the views of young people on the delivery of school-based support for emotional wellbeing (Kendal, Callery, & Keeley, 2011; Kendal, Keeley, & Callery, 2011).

Participants were particularly concerned about the confidentiality of the organised PSI, as the peer helpers might share the identity of the discloser with adults or "go out and tell other students what's happening in your life." This distrust was compounded by the likelihood that the trained helper would be an unknown person who was not necessarily trustworthy. This is consistent with Kendal, Keeley, and Callery's (2011) finding that young people in the UK considered peer mentorship (an organised PSI) unappealing, because the peer supporters were not trusted. Low take-up of PSIs by pupils due to lack of trust in peer supporters was also raised as a concern in Coleman et al.'s (2017) review of organised PSIs. The importance of confidentiality is particularly relevant to the adolescent social

context, due to the increasing likelihood of rumour-spreading as a form of peer victimisation in adolescence (Troop-Gordon, 2017).

Online PSIs were viewed favourably as they had the most potential for anonymity: “Like the person . . . expressing their problem is anonymous, and the person on the receiving end is anonymous, so you could get advice and you never know who it is, so it’s safe.” However, there were still significant concerns about the security of an online system. Adults might also interfere and escalate problems: “But again it’s the lack of confidentiality, like the adult will definitely take something they see and probably escalate it if they think they should.” This was also a significant concern for participants deciding with whom to share their problems (RQ2.1 Subtheme 1.2).

Theme 3 Popularity and impact.

Subtheme 3.1 Breadth of impact.

A prevalent theme across all three PSIs was how broad the impact would be. Some participants were positive about the potential impact of the online PSI: They felt that it would enable pupils to share advice with lots of people. Four of the six groups suggested that the scope of the online system should be broader than their school. They argued that a forum or website allowing pupils to share problems across their geographical area or the whole country would improve the anonymity of the system and provide opportunities to gain advice from a broader spectrum of young people:

> I think quite a few people would actually use that, because they’re getting ideas off other, other peers from all around where they live, and they, and no-one will ever find out who it was who posted that, and who asked, who gave the advice.

The impact of the online PSI also had limitations, however. Participants acknowledged that it might not be well-used and that some students might lack the technology to access it.

It was suggested that an organised PSI might be effective for younger year groups, particularly students in Year 7 who “might have left their friends at primary school.” However, most participants were negative about the potential impact of organised PSIs. They felt that the system would be under-used, especially if poorly advertised: “No-one’s going to be there, you can’t just, you can’t just pick

a person up and say, ‘Oh this is where you come,’ plonk, there, you cannot do that like.”

Some groups felt that the universal PSI may have more impact than the organised and online PSIs, as “it gets across a wider group.” However, it wasn’t considered suitable for everyone. One group noted that the impact of the universal PSI depended on pupils having friends already. Since the intervention requires pupils to have friends with whom to discuss problems, it would not benefit individuals lacking a key element of eudaimonic wellbeing: trusting relationships with others (Keyes, 2005). There is a wealth of research emphasising the role of peers for various elements of mental health in adolescence (Corsano et al., 2017; Gorrese & Ruggieri, 2013; Oberle, Guhn, Gadermann, Thomson, & Schonert-Reichl, 2018; Rasalingam, Clench-Aas, & Raanaas, 2017). The universal PSI may therefore have limited impact on young people who are likely to be further down the mental health continuum than others (Keyes, 2002, 2005).

Participants also felt that pupils may not apply what they had learned in the universal PSI to their discussions with friends: “Because like at the end of the day you’ve got a teacher saying, ‘You need to help, you need to say this,’ and the person doesn’t.” One group suggested that it could have more impact if it was delivered earlier in pupils’ education, because this is when “you learn all of the important things that you’re supposed to be knowing for your later life.”

Subtheme 3.2 Engagement.

One limitation of the universal PSI was the challenge of engaging pupils with the material. Some participants felt that the content would be useful: “I feel like it would be helpful to like people because sometimes I get really stressed about whether I’m a help or not to my friends.” However, several groups felt that they had had similar input before and that the content would not be engaging, particularly if delivered by an adult in an assembly-style format:

> I don’t think like, just an adult standing up and like giving or expressing what it is to deal with issues or to help others is the most like intriguing way or the way to like, to actually get a teenager to listen and to really think about it.

Participants suggested more creative and engaging ways to portray the information: smaller groups, the use of role play to demonstrate skills, and

communicating the information in a variety of ways. These are features of YAM: a universal intervention to raise mental health awareness which includes role play in small groups (C. Wasserman et al., 2015). D. Wasserman et al. (2015) found that it was associated with a significant reduction of suicide attempts and severe suicidal ideation. They felt that the pupils' active participation and engagement with the programme made it more effective than other interventions. The participants in the current study identified the effective elements of YAM; this supports the idea (on which this study is based) that gaining and implementing the views of those expected to use a school-based intervention will improve its likelihood of success.

Theme 4 Quality of help.

Subtheme 4.1 (In)experience of peers.

Participants were concerned that the helpers in the organised and online PSIs would lack the experience to offer effective advice to pupils using the systems. They suggested that the helpers should be trained, supported by adults, or selected specifically for their experience with particular problems. Several groups were sceptical of adults recruiting potentially inexperienced or unwilling pupils to organised PSIs who "might not be up for the job": "They give them a badge and they're like, 'There you go, this is who you can go to.'" Lack of sufficient training for helpers was also a concern for 16-24 year-old participants in an Australian study regarding use of online services for help-seeking (Stretton, Spears, Taddeo, & Drennan, 2018). The current study demonstrated that this is a concern for younger adolescents, in the context of school-based PSIs. Participants suggested that the online PSI could be used for "easy to deal with problems." Coleman et al. (2017) also found that adult support and supervision of peer supporters was vital to the success of PSIs, to avoid pupils having to offer support beyond their capabilities.

Participants did not raise concerns about the ability of adolescents to support one another when discussing the universal PSI. They seemed more confident in the ability of their own friends to support them than pupils identified as helpers within a system: "You might as well just say go to a classmate instead of going to someone who you've seen once in your life around school." This implied a belief that their own friends were inherently more reliable and trustworthy than those

selected by the school within an organised or online PSI. In this context, participants repeated some of the reasons for disclosing to a friend that were raised in RQ2.1: personalisation of the help, higher likelihood of confidentiality, and feeling more comfortable. Coleman et al. (2017) found that PSIs may suffer from low take-up, possibly due to lack of trust in the peer supporters. The current study helps to explain why adolescents prefer to rely on their own friends for support, rather than peers who have been selected as part of an organised system.

Subtheme 4.2 Adult support.

Participants mostly viewed the involvement of adults in online and organised PSIs as positive, particularly to offer help with serious problems: “If people don’t like respond properly [in the online PSI], then you need an adult to tell them what to say.” This is consistent with the finding that participants preferred to seek adult support for serious problems (RQ2.1 Subtheme 3.2). Contradictorily, in the context of the universal PSI, the absence of the adult in the process of disclosing problems was considered an important element of its potential success, for reasons also outlined in RQ2.1 Theme 4: “I think it’s more personal because instead of like an adult knowing what you’re saying to your friends, it’s like obviously like you go to your friends with a personal problem, so you feel more comfortable explaining it.”

The finding that participants felt that adult support was needed only within the organised and online PSIs supports the implicit view in Subtheme 4.1 that advice within existing friendships is more reliable than advice given by peers within an organised system. It suggests that adolescents are more likely to seek advice from their own peers than to use a system, implying that the universal PSI might be the most impactful intervention.

One group considered the expertise of the adult delivering the universal PSI to be a benefit of this PSI-type. However, there were also concerns that even from an expert, generic advice would not be effective: “You can’t really have a guideline of how to help your friend because each friend is different.” Participants thus recognised the complexity of supporting friends with challenging problems and highlighted the need for universal PSIs to address this complexity.

Theme 5 Risks.

Subtheme 5.1 Inappropriate use.

Participants were concerned that the organised and online PSIs would not be used appropriately: Some pupils might use the online PSI as "a kind of inside school text forum" and "treat it as a joke." This was particularly concerning for participants as the online nature of the system meant that there would be "no way of controlling how it's going to be used." Some groups felt that having an adult involved in the online PSI would help to "stop people like being negative towards each other" or to "flag like something that shouldn't be there."

Similarly, there were concerns that the universal PSI would not be taken seriously:

> I think a lot of people kind of like, they don't really realise how serious like mental health and stuff like that, and they might not take it in and then like later it could be used but they haven't took it in.

This relates to the idea raised in RQ2.1 Subtheme 2.1 that problems might be brushed off by friends. I interpreted this as discrimination through avoidance. In this context, participants were concerned that the whole subject of mental health might be mocked and belittled. The phenomenon of treating issues as a joke was not found within existing models and measures of stigma (e.g. Gierk, Löwe, Murray, & Kohlmann, 2018; King et al., 2007; Mason et al., 2015). Future research could further examine the prevalence and impact of light-hearted and dismissive attitudes towards other people's problems and the subject of mental health.

Subtheme 5.2 Dangers.

Participants were aware of specific dangers relating to online and universal PSIs. Online safety was a concern for the online PSI, including the risk of "brutal" cyber-bullying and the forum becoming a "toxic community that is very difficult to eliminate." By recognising this as a problem specific to the online PSI, participants demonstrated awareness of the toxic online disinhibition effect, in which people act harshly online in ways which they would not face-to-face (Suler, 2004). Cyberbullying can have negative effects on various elements of mental health, including an increased likelihood of developing a mental illness (Nixon, 2014). The experience of cyberbullying can also lead to more negative attitudes towards

help-seeking (Gustainiene & Valiune, 2015). Cyberbullying on an online PSI may therefore negate any positive effects of the system.

There was also a perceived risk that the mental health-related content of the universal PSI could cause distress to young people. By highlighting the importance of friendships, the universal PSI was also perceived as potentially upsetting for pupils who do not have friends:

> Participant A: Yeah "How to help your friends." What about if you haven't got friends? That is the problem. There could be kids in there that have loads of friends, there could be kids in there that have no friends.
>
> Participant B: And then that highlights the people that don't.

These findings reflect concerns that education programmes for mental health may have a negative impact on participating young people (Hawton et al., 2012; NICE, 2015). There is limited research into whether this is the case. Hawton et al. (2012) referred to a study in which psychological skills training for school pupils reduced suicidal ideation, but also led to increased anger and reduced school connectedness. However, the study (Cho, Hallfors, & Sánchez, 2005) put at-risk youth into groups to access the intervention; the negative effects may therefore have been a result of the means of delivery, rather than the content of the intervention. Further research is required to establish whether participation in universal programmes for mental health has negative outcomes for young people, and whether such outcomes would outweigh the potentially life-saving effects of such programmes (D. Wasserman et al., 2015).

The participants proposed a solution to the problem: delivery of the universal PSI in smaller groups, rather than as a whole-year or whole-class assembly. They felt that individual circumstances could thus be more easily taken into account when delivering sensitive content.

Theme 6 Keeping quiet.

Subtheme 6.1 Shyness, stigma and shame.

Participants felt that a major limitation of the organised PSI was the embarrassment of using it:

> If you've got a buddy system then you'd just be, like take the mick out of you for going to go to like, because . . . you don't just go and talk to

> someone about your problems . . . people take the mick out of you with stuff like that.

Using an organised PSI could therefore lead to peer victimisation, which has been found to have a negative impact on the everyday life of adolescents and to significantly increase the risk of mental illness (Rasalingam et al., 2017).

Furthermore, participants felt that using an organised system would require confidence that vulnerable individuals may lack. The individuals who could most benefit from the organised PSI may therefore be least likely to be able to use it: "If you've got two people who like, they could be your buddies but you don't have the confidence to go talk to them, then it kind of, kind of just cancels out the whole point of it." Organised PSIs may be inaccessible to individuals lacking an element of eudaimonic wellbeing: autonomy, which allows people to exhibit self-direction and resist social pressures (Keyes, 2005). Individuals who lack the autonomy to use an organised PSI are likely to be further down the mental health continuum (Keyes, 2002, 2005) and may therefore be in more need of support. Participants suggested that a more private system, such as allowing pupils to write their problem down, would help to address this problem.

Three groups discussed the stigma and shame surrounding the idea of sharing a problem:

> Because like, if you have something going on at home or something, and you like drew a tear or something, I don't, people, people don't sort of like tend to take that well, and just, and like, they don't bully you, they like, they just take the mick a bit.

This is consistent with literature showing that perceived stigma is a barrier to help-seeking for mental illness (Clement et al., 2015; Gulliver et al., 2010). Whilst some groups felt that their generation was more literate in mental health than previous generations (Subtheme 1.2), stigma around help-seeking for any personal problem continued to affect their willingness to seek help. Research also highlights the importance of the initial disclosure of a mental health problem being received positively (Gulliver et al., 2010). The current study demonstrated the risk that disclosing problems to peers in adolescence may result in the individual experiencing stigma in the form of being teased.

One group suggested that this was a more significant problem for boys. This is consistent with research showing that gender role self-concept affects adolescents' willingness to seek help for a range of problems: Those identifying

with masculine norms were less likely to seek help (Kessels & Steinmayr, 2013; Sears et al., 2009). Research also suggests that female friendships may involve more positive responses to disclosures of problems than male friendships, due to females having higher levels of empathy and emotional understanding (Białecka-Pikul et al., 2017; Wölfer et al., 2012). Males may also be reluctant to display vulnerability due to the prominence of issues relating to power and status within male adolescent friendships (Goede et al., 2009).

Some participants felt that universal PSIs could help to reduce stigma around sharing problems, and encourage discussions between friends about difficult issues: “Like I know we’ve had stuff like that before, and then afterwards people have like, like been encouraged to speak out, like if there’s something going on, they’re been like encouraged to just say what’s on their mind.” However, embarrassment and shame could be an issue if attendance at the universal PSI were voluntary: “Like if that was voluntary and you turned up to one of that like and the, say if people are there, where people saw you doing that . . . I would be quite embarrassed to be fair.”

Subtheme 6.2 Why use a system?

The stigma addressed in Subtheme 6.1 may be implicated in the disparagement that members of one group expressed towards the idea of using a system to cope with issues such as bullying. They felt that it would be better to rely on making one’s own friends than to use a system: “You might as well just go and play football . . . literally something that you’re good at, whether it’s dancing or. Get a mate that’s also like kind of by their self, individual. . . . Yeah no point using a system.” This finding supports my proposal in Section 2.4 of this thesis that definitions of school-based PSIs should include informal peer support as well as structured PSIs that are planned and implemented by adults (Coleman et al., 2017). Some participants felt that relying on one’s own friends was a preferable alternative to using the organised PSI, thereby distinguishing between formal and informal peer support. These participants were particularly disparaging about the notion of using a system in place of real friendships.

Other groups recognised the benefits of having an organised system as a back-up to existing friendships, where individuals can find a reliable source of support: “It is helpful because then . . . like they’ve got a place where they feel they’re

wanted, they've got someone to talk to and they can take their mind off things." One group felt that using an organised PSI might help pupils to make new friends, thereby helping them to eventually become independent of such systems.

Subtheme 6.3 Right to remain silent.

As well as recognising that stigma and shame can discourage people from sharing problems, most groups discussed the idea that some people prefer to keep problems to themselves: "Even if they are fine with their friends, [some people] don't like talking about their problems, they find it too personal."

One group were concerned that PSIs, particularly the universal PSI, could create pressure to share problems, which could make pupils feel worse. As such, they emphasised people's right to remain silent on personal problems unless they decide to "do it in their own time and own pace." This reluctance to share problems may be motivated by *internalised stigma*, in which an individual anticipates social rejection on the basis of stigmatising attitudes to the problem (Corrigan, Kerr, & Knudsen, 2005). Internalised stigma has been negatively associated with psychosocial variables such as hope and self-esteem (Livingston & Boyd, 2010). However, the participants in this group felt that an individual's desire not to share personal problems should be respected. As this study was motivated by the importance of respecting adolescents' views, this finding should be taken into consideration in the design and implementation of PSIs.

Key findings.

The participants took the following factors into account when considering what makes an effective PSI:

- Is it appropriate for my age group?
- Is it appropriate for my generation: Does it make use of technology and account for our existing knowledge of mental health?
- Is it genuinely confidential?
- How broad is the impact: that is, how many people does it reach?
- Is it accessible for pupils who might need it most, such as those who lack confidence or do not have friends?

- Are the peer supporters experienced and knowledgeable enough (with or without adult support) to offer helpful advice?
- Is it used appropriately and taken seriously?
- Might it cause problems such as peer victimisation or cyberbullying?
- Does it address stigma about seeking help for problems?
- Does it respect my right not to share problems if I do not want to?

7. Overall Discussion

The two phases of this study examined the phenomenon of peer support between adolescents. It aimed to explore how adolescents support one another with personal problems and why they might prefer to rely on peers for support. It also aimed to examine the role of secondary schools in helping adolescents to support one another through the implementation of school-based PSIs, by gaining the views of pupils. Simultaneous examination of the results of both phases provided further useful analysis in response to the aims of the research. In this section, I outline and explore some of the themes which link the two phases of the research. I then consider the strengths and limitations of the study.

7.1 Themes Linking Phases 1 and 2

Confidentiality and sharing.

Confidentiality and sharing is a theme which was pertinent across both phases of the study. In Phase 2, confidentiality was an important consideration for participants: both when they were considering with whom to share a problem and when discussing the usability of school-based PSIs. The prominence of this theme is consistent with existing literature on help-seeking and self-disclosure (Clement et al., 2015; Corry & Leavey, 2017; Leavey et al., 2011).

There was some contradiction between the findings of Phases 1 and 2 in relation to this theme. In Phase 2, the participants were very concerned with whether or not the disclosee would keep their problem confidential; in Phase 1, many participants were willing to act on the vignette-character's disclosure of a serious problem without the character's permission. The most common action was to tell somebody else about the friend's problem. Therefore in Phase 1, which was from the perspective of the disclosee rather than the discloser, participants were willing to break confidentiality to help their friend: something that participants in Phase 2 wanted to avoid. This finding reveals the complexity inherent in the important role of trust within adolescent friendships (Brown, 2004). One explanation for this conflict is that there are likely to be differences between actual and intended actions (Mason et al., 2015). Another is that in Phase 2, participants stated that adults should be involved for serious problems. The Phase 1 participants may

have felt that the severity of the problems disclosed by the vignette-characters justified breaking confidentiality and involving an adult.

Escalating a friend's problem by passing it onto an adult is a form of prosocial risk-taking, in which an action taken to benefit another individual incurs a cost in the form of a risk, including social risks such as losing valued friendships (Do et al., 2017). The combination of Phases 1 and 2 shows the extent of this risk (as Phase 2 participants considered confidentiality an important element of sharing problems with friends), but also that many Phase 1 participants were aware of the need to take this risk at times, whether or not they would carry out the intention in reality. These findings demonstrate the complex dynamics that disclosures of personal problems can lend to adolescent friendships.

A potentially less risky response to a friend's disclosure of a serious problem would be to encourage the friend to tell an adult, rather than breaking confidentiality. In Phase 2, some participants felt that they had a responsibility to involve an adult if they felt their friend was at risk. Others argued that adults should not be involved, as problems could be escalated. There were also concerns about specific groups of adults, for example that teachers would want "gossip" about their pupils and not take the problem seriously. These findings may help to explain the fairly low rates of Phase 1 participants who encouraged the vignette-character to talk to an adult (around half of respondents). Whether to involve an adult is evidently a complex source of conflict for adolescents receiving a friend's disclosure.

Online or face-to-face?

The current generation of young people can be described as "digital natives" (Prensky, 2001, p. 2), and some developmental tasks of adolescence may now be enacted online (Valkenburg & Peter, 2011). The current study demonstrated the centrality of technology to problem-sharing in adolescence. Phase 1 showed that many participants had received disclosures of friends' personal problems online. Phase 2 demonstrated why this might be: adolescents' preference for using technology and thereby avoiding the perceived awkwardness of face-to-face interactions. Phase 2 also showed how school-based PSIs can adapt to this phenomenon, by offering online methods for pupils to share problems with peers.

Whilst online problem-sharing was common, only 14% of Phase 1 participants stated that their friends predominantly shared problems using technology (as opposed to face-to-face), and several Phase 2 participants felt that face-to-face interactions were preferable to online discussions. Phase 2 participants also discussed the dangers of using online systems to share problems, such as lack of anonymity, abuse of the system, and cyberbullying. The findings of Phase 1 and 2 suggest that schools may need to provide opportunities for pupils to disclose problems to peers both online and face-to-face.

Stigma and embarrassment.

Stigma around problem-sharing was relevant to Phases 1 and 2; it is also a common theme in existing literature about help-seeking (Clement et al., 2015; Gulliver et al., 2010). In Phase 2, participants discussed concerns that friends might tease them for wanting to discuss a problem. My interpretation was that the light-hearted dismissal of a friend's problem could constitute a form of stigma through avoidance of the problem, possibly due to discomfort discussing difficult issues. Some Phase 1 participants reacted to the vignette-disclosures with dismissive or negative comments. Although this was a small proportion of respondents, it shows that adolescents disclosing serious problems to peers may face a stigmatising response, as feared by the Phase 2 participants. This may be particularly challenging within the context of adolescent friendships; vulnerability to ridicule can have significant social consequences, such as reduction in status and power within the friendship group (Adler & Adler, 1995; Troop-Gordon, 2017). The desire to be socially accepted by peers is likely to contribute to adolescents concealing personal problems which could leave them vulnerable to negative social consequences (Corsano et al., 2017).

Are PSIs needed?

Phase 1 explored the phenomenon of problem-sharing between adolescent peers. One aim of the study was to consider how the design and implementation of school-based PSIs could be informed by the views and experiences of young people. PSIs were explored in detail in Phase 2. An important consideration for

this study was whether school-based PSIs would meet a need in supporting the mental health of adolescents at school.

Findings from both phases suggest a need for school-based PSIs, in order to support adolescents to help friends with personal problems. Phase 1 demonstrated that secondary school pupils frequently discuss problems about a range of topics. Over half of participants (52% of males and 79% of females) gave an example of a problem with which they had struggled to support a friend; many of these were serious problems, such as family conflict, bereavement, bullying, and signs of mental illness. Phase 2 participants discussed the guilt and self-blame that can occur when receiving a disclosure of a serious problem from a friend. These findings suggest that while adolescents experiencing personal problems need support through the provision of effective help, interventions such as PSIs may also support the mental health of pupils who receive disclosures of friends' problems, by alleviating some of the difficult emotions that this can involve. Such interventions may support both hedonic and eudaimonic wellbeing: Young people may experience hedonic wellbeing (i.e. feel happier) when they perceive that they are supporting a friend effectively; they may also develop elements of eudaimonic wellbeing such as social acceptance, social contribution, and positive relations with others (Keyes, 2005).

Findings from Phases 1 and 2 suggest that participants may vary in whether they feel they would benefit from support in helping friends. Phase 1 participants' self-reported confidence in responding to the vignettes was moderately high. However, disappointingly low rates of participants responded to the vignette-characters in ways which professionals would consider helpful, such as encouraging them to connect with an adult and checking if they had considered suicide (Ross et al., 2012). Phase 2 participants suggested that their generation had "heard it all before" and were knowledgeable about issues relating to mental health. This was a perceived limitation of the universal PSI, which pupils might find boring and unengaging. These findings suggest that while adolescents may benefit from further information on how to support friends with serious personal problems, a key challenge would be encouraging them to recognise the benefits of such education and to engage with and apply the material.

7.2 Strengths and Limitations

I now outline some of the strengths and limitations of the study, relating to the sample, methodology, and procedure.

Sample.

The study used a convenience sample: All schools in the LA were invited to participate, and all three schools who responded were included. It took place in a predominantly white British population across three wards in an urban LA in the West Midlands. The schools were in three different wards of the LA, and there was some variability in demographic across the three schools, such as pupils whose first language is not English (1-24%) and pupils eligible for free school meals (26-62%). Nevertheless, this was not a representative sample, so findings cannot be generalised to adolescents across the country.

Phase 2 used a traditionally qualitative research method. Using focus groups allowed me to gain more perspectives than using individual interviews, thereby helping to achieve data saturation (Fusch & Ness, 2015). Quality of sampling in qualitative research relates to the richness of the information rather than the number of participants; an adequate sample size is one which can provide the richness and depth of information needed to answer the RQ (O'Reilly & Parker, 2012). I found that in the final focus groups, few new themes emerged from the data, suggesting that data saturation may have been reached.

A limitation of the Phase 2 sampling was that the school-links selected the participants. They were asked to randomly select pupils within my criteria: an even number of males and females, and a range of academic abilities. However, there may have been variations in how school-links selected participants within these criteria. Also, since active parental consent was required, participants were limited to those whose parents returned the permission slip. Pupils whose families lead more chaotic lives or are less engaged with education may therefore have been excluded. A future replication of this study could further ensure that the sample was representative of a range of students.

Methodology and procedure: Phase 1.

In Phase 1, self-administered written questionnaires were used to collect data. One limitation was the number of vague responses to open questions. For example, relatively few responses specified which adult the participant would tell about the vignette-character's problem. An alternative data collection method such as interviews would have elicited more detail, as I could have sought clarification for vague answers (Mason et al., 2015). Due to the brevity of some answers to open questions, the questionnaire may not have captured the full scope of participants' intentions in response to the vignettes, thereby affecting the validity of the study (Coughlan et al., 2007).

The high number of responses stating that the participant would tell an adult about the problem may have been affected by the example provided in the questionnaire, "e.g. tell an adult." During the questionnaire design, I felt that providing an example response would prompt more detailed answers to this open question; however, it may have distorted responses by prompting demand characteristics in the participants (McGhee, 2001). Another limitation is that in response to multiple-choice questions, some participants ticked just one option for each question, despite the question stating, "Tick all that apply." Participants may have rushed through the questionnaire or misunderstood the instruction. This would result in false negatives, as it was assumed in the analysis that participants who did not tick the box had actively chosen not to respond in that way. This also affects the validity of the study (Coughlan et al., 2007).

Phase 1 captured participants' intentions in response to hypothetical scenarios, rather than actual actions; responses may not be reflective of how participants would respond in reality. Mason et al. (2015) measured MHFA intentions in response to a vignette, and actual actions taken by participants to support people they knew. They found that helping the individual to connect with an adult was more commonly reported as an intention than as an action. However, examining intentions is a valuable area of study, as it demonstrates participants' beliefs about the right thing to do. Future studies using alternative data collection methods may use this information to consider whether adolescents apply this knowledge in reality.

A strength of the Phase 1 methodology was the fact that I designed the research instrument. Although there were similar existing studies and measures, I felt that

none of them captured the unique scope and focus of the current study (Section 8.3). The aim of designing a new research instrument was for the questions to be clearly linked to the RQs and to elicit information to meet the aims of the research (Coughlan et al., 2007). Another strength was the use of a pilot study with pupils who were the same age as the intended participants. The aim was to ensure as far as possible that the instrument would be clear and unambiguous to participants and that it would measure the areas set out by the RQs and the aims of the study (Coughlan et al., 2007). The piloting process helped me to clarify some of the questions and improve the validity of the study.

Methodology and procedure: Phase 2.

Qualitative research is often evaluated by examining the study's rigour: the means of demonstrating the plausibility, credibility, and integrity of the research process (Ryan, Coughlan, & Cronin, 2007). The rigour of Phase 2 was demonstrated in the following ways:

- use of a pilot study to test the focus group schedule;
- precise data analysis following a clear system (Braun & Clarke, 2006, 2013; Terry et al., 2017), and an in-depth description of the process (Section 3.7; Critical Appraisal Skills Programme [CASP], 2017);
- critical reflection on data collection and analysis (Section 7.2); and
- participants from a range of schools to enhance the transferability of the findings, particularly as similar themes were raised in all three schools.

Due to time constraints, it was not possible to check the consistency between participants' views and my representation of them by gaining respondent validation (CASP, 2017). However, I took measures to improve the credibility of the study: regular clarification of participants' views throughout the data collection process; review of the original data set at regular intervals throughout the data analysis; and critical examination of my role and possible biases in the research process (Section 7.2).

Data triangulation helps to achieve data saturation (Fusch & Ness, 2015). This study only included participants' self-reported data. Whilst the study was in two phases, the phases were designed to complement one another and contribute to new knowledge, rather than to collect different types of data on the same topic.

This limits the ability of the study to reach data saturation. The concept of saturation in qualitative research is contentious, however, and O'Reilly and Parker (2012) argued that it should not be applied unquestioningly to all qualitative research. They added that if saturation is not reached, it means that the phenomenon has not yet been fully explored, not that the findings of the study are invalid. This study does not claim to fully explore the phenomenon of peer support in adolescence; rather, it adds to the body of knowledge in this area and identifies areas for further study.

Researcher reflections: Phase 1.

Drisko and Maschi (2015) note that researcher self-reflection is rarely mentioned in basic content analysis, but that it can help to address the conceptual limitations of the approach and the role of the researcher's personal biases. In this section, I reflect on my role in the process of content analysis.

I was conscious of Krippendorff's (2004) criterion that codes should be mutually exclusive and exhaustive: that no code should fall between two categories or be represented by two distinct data points. This was challenging when coding the responses to the vignettes, due to the varied specificity of the responses. For example, many responses referred to telling an (unidentified) adult, while others specified the adult whom they would tell. As a result, a code was created for telling an unidentified adult, and answers which specified the adult were coded separately.

Another complication was that some answers covered multiple ideas. For example, "Go with him to tell his parents" included the notions of going with the friend to get help, and telling his parents. In these instances, I considered the answer to comprise two distinct units and coded them separately. The example above was coded under "Go with him" and "Tell parents." Individual answers could therefore be divided into multiple units, but no unit was coded twice, thereby meeting Krippendorff's (2004) criterion of mutually exclusive codes.

There was ambiguity in some responses. I considered it impossible to code some responses meaningfully, due to vagueness (e.g. "Explain what happened") or obscurity (e.g. "Take the L"). These responses were coded under "Unclear answer." Some responses relied on my interpretation of latent content, that is,

meaning not explicit in the response itself (Drisko & Maschi, 2015). For example, I interpreted the response “Don’t worry” as a supportive comment and it was coded under “Encourage and support.” However, I interpreted a similar response (“This isn’t something to worry about”) as dismissive, and therefore coded it under “Negative/Dismissive comments.” As a result, some elements of the coding process were affected by my assumptions and personal interpretations.

Researcher reflections: Phase 2.

Phase 2 used a traditionally qualitative research method; qualitative research is a subjective process significantly influenced by the researcher (Braun & Clarke, 2013). Reflexivity is an essential element of such research: It involves the researcher acknowledging how personal interests and values influence the research process, through ongoing critical reflection (Banister, Burman, Parker, Taylor, & Tindall, 1994; Lichtman, 2013). I kept a research journal throughout the process, to ensure that reflexivity was an integral part of the research process. In this section, I outline some ways in which my views and identity influenced the collection and analysis of Phase 2 data.

Bias towards universal PSIs.

I had a personal bias towards universal PSIs, as opposed to organised and online PSIs. This was partly motivated by the exclusion of universal PSIs in previous reviews of PSIs (e.g. Coleman et al., 2017) and the effectiveness of YAM, a universal PSI (D. Wasserman et al., 2015), as outlined in Section 2.4. I therefore expected the participants to be most enthusiastic about this PSI-type. Remaining conscious of this bias enabled me to take care not to communicate this view when presenting the PSI-types to the participants. As the findings indicated that the universal PSI was not the most popular PSI-type, my bias may not have strongly directed the data collection and analysis. If the study were replicated, the order of PSI-types should be counterbalanced; in this study, the universal PSI was consistently presented last, which may have betrayed my bias towards it.

In one school, focus groups took place before the delivery of the Phase 1 questionnaires, which led to some confusion among participants regarding the next stage of the research. Comments from some participants suggested that

they expected me to deliver a universal PSI in the next phase of the research (e.g. saying “no offence” when talking about the universal PSI or suggesting that the deliverer of the PSI would be from the University of Exeter). This may have affected the expression of these participants’ views about this PSI-type. However, the participants in these groups still offered criticisms of the universal PSI, suggesting that this misconception did not significantly affect the data collection.

Researcher-participant relationship.

During data collection and analysis, I was conscious of the differences between me and the participants, particularly in terms of age, accent, and power. This may have affected participants’ willingness to express their views, and my interpretations of their views during data analysis. I feel that focus groups were an appropriate research method to mitigate these effects. This research method shifts the emphasis and power from the interviewer to those being interviewed (Lichtman, 2013). The use of group interactions is a critical element of focus group research (Lichtman, 2013), and disagreements between participants may be less intimidating for young people than having their views challenged by an adult (Liamputtong, 2007). By giving participants opportunities to disagree and debate with one another, I aimed to have minimal input in the discussions.

To ensure that the participants felt comfortable and to minimise my impact on the data collection, I used a number of strategies during the focus groups. As suggested by Lichtman (2013), I left silences that sometimes felt awkwardly long, to allow space for the participants to give their views and to encourage them to fill these spaces. I also minimised my contribution to the focus groups by limiting my comments to: introducing new topics for discussion, encouraging elaboration on what had been said, and clarifying what a participant had meant. As participants sometimes used my clarifying comments to disagree with my interpretation, I felt that I had successfully empowered them to express their honest views.

I also used techniques to create a relaxed atmosphere in which participants felt able to give an honest critique of the PSI-types I presented. The use of drawings (Appendix D) helped to create this dynamic, as I showed vulnerability by admitting the inadequacy of my artistic skills. Participants felt able to laugh at the pictures, which helped to address the power imbalance inherent in the relationship

between adult researcher and adolescent participants. Eliciting agreements and disagreements within the group also helped to draw quieter members of the groups into the discussion, as they were given opportunities to express their views without having to initially volunteer them.

Data analysis.

To ensure that the final analytic report was true to participants' views, I returned to the data set throughout the thematic analysis and made changes to themes and subthemes based on this iterative review process. After writing the report, I ensured that all six focus groups were represented in the quotations throughout the report. It was not possible to ensure that every participant's views were equally represented, due to the difficulty of identifying individual participants in the focus group recordings. I tried to remain conscious of my influence throughout the data analysis, to minimise the impact of personal bias. However, thematic analysis is a subjective process, and it is therefore inevitable that my views, values, and personal experiences (as outlined in this section and Section 1.4) influenced the production of the final analytic report.

8. Implications and Conclusion

One of the aims of the study was to inform the development and implementation of school-based PSIs which adolescents would consider effective. The implications of the study for schools and EPs are outlined in this section, including considerations for school-based PSIs and implications from other findings. I then describe the unique contribution of the study to the field and suggest areas for future research. The concluding comments summarise how the aims of the study were met and briefly locate the findings within Keyes's (2002, 2005) mental health continuum.

8.1 Implications for Schools

Designing and implementing PSIs.

This study aimed to provide information to support schools to develop and implement PSIs which are sensitive to the views and experiences of adolescents. In Phase 2, pupils in Year 9 were presented with three types of PSI: organised, online, and universal PSIs. The participants discussed the advantages and disadvantages of each PSI-type, which are summarised in this section.

Organised PSIs.

Organised PSIs were defined as a system set up and overseen by an adult, for pupils to help each other with problems, such as a buddy system. Participants felt that the advantages of organised PSIs were that:

- they might be effective for younger year groups,
- peer helpers could be trained or selected based on their experience of particular problems,
- adults could support peer helpers with difficult problems,
- pupils could use them as a back-up when they could not rely on their own friends, and
- they could help pupils to make new friends.

The perceived disadvantages of organised PSIs were that:

- they are often childish and therefore inappropriate for secondary school,
- peer helpers could break confidentiality,

- they would not be used by many pupils,
- they are often poorly advertised,
- peer helpers may be inexperienced or unwilling to adopt their role,
- using them could lead to teasing or bullying,
- they require confidence to use, and
- it is better to make one's own friends than to rely on a system.

Online PSIs.

Online PSIs were defined as an online system set up and overseen by an adult, for pupils to help each other with problems, such as an online forum where pupils post and advise on problems. It is a type of organised PSI, which is run online. Participants felt that the advantages of online PSIs were that:

- they are suitable for this generation;
- they avoid the awkwardness of face-to-face discussions;
- they have higher potential for anonymity than the organised PSI;
- they could reach a high number of pupils;
- they could have scope beyond the school, thereby improving anonymity and gaining advice from a broader range of young people;
- peer helpers could be trained or selected based on their experience of particular problems;
- they could be useful for minor problems; and
- adults could support helpers with difficult problems and ensure appropriate usage of the system.

The perceived disadvantages of online PSIs were that:

- the system could be insecure and therefore not anonymous,
- adults might interfere and escalate problems,
- they might not be used by many pupils,
- they do not help adolescents to develop interpersonal skills,
- pupils require access to technology to use them,
- peer helpers may be inexperienced or unwilling to adopt their role,
- the system could be used inappropriately,
- online systems are difficult to control and regulate, and
- there is a risk of cyberbullying on the system.

Universal PSIs.

Universal PSIs were defined as a system in which all pupils are given instruction by an adult on how to improve the support that they give to their friends, such as how to listen and when to involve an adult. Participants felt that the advantages of universal PSIs were that:

- they could reach a large number of pupils;
- they could help to reduce stigma and encourage disclosures;
- one's own friends are more trustworthy and approachable than peer helpers selected by the school;
- adults are not involved;
- the person delivering the instruction could be an expert in the area;
- information could be conveyed in interesting ways, such as in small groups and using role play;
- small groups could take into account pupils' individual experiences; and
- they could be effective when pupils are younger.

The perceived disadvantages of universal PSIs were that:

- pupils may have heard about the topic before and might find it boring;
- pupils may not engage with the material, particularly if it is delivered as an assembly;
- pupils may not take it seriously;
- pupils may not apply the learning in real life;
- it is not possible to give generic advice due to the individuality of one's friends;
- upsetting content could distress some young people;
- they only benefit pupils who have friends already;
- they could be distressing for pupils without friends; and
- they could create pressure to share problems before the pupil is ready.

Summary.

The findings of the study suggest that the following should be taken into account when designing and implementing school-based PSIs.

- PSIs should account for the social changes that occur in adolescence; interventions which are effective in primary school are unlikely to transfer successfully to a secondary school setting.
- PSIs should provide a range of ways for pupils to communicate their problems, both online and face-to-face.
- Care should be taken to ensure that PSIs do not have negative consequences for pupils' mental health, such as cyberbullying or peer victimisation.
- The extent and limits of confidentiality and anonymity in PSI systems should be made clear, to reassure pupils that they can be used safely and to prepare them for when confidentiality may need to be broken.
- There should be PSIs that benefit individuals who do not have close peer relationships, as these pupils may be at higher risk of poor mental health.
- Adolescents might benefit from universal programmes about how to respond to a peer's disclosure of a serious problem (e.g. assess the risk of suicide and encourage the friend to tell an adult).
- Universal PSIs need to engage pupils. This could be achieved by:
    - delivering small-group sessions using creative techniques such as role play;
    - addressing perceptions that the information may not be relevant;
    - acknowledging pupils' existing knowledge of mental health; and
    - acknowledging features of adolescent friendships, such as reluctance to break confidentiality.
- Mentoring-style programmes may be effective when the mentor has experienced similar difficulties to the mentee.
- The transition into secondary school is challenging for children, partly due to the social changes occurring in adolescence. Younger pupils may benefit from structured support such as organised PSIs to help them navigate these social changes.

The design of the study demonstrated that adolescents have opinions on the school-based interventions which are designed to support them, and that they

can express these views when given appropriate opportunities. When pupils are expected to use an intervention voluntarily, it is particularly important to gain their views on how to maximise its impact. Consulting with those for whom the intervention is intended is likely to provide helpful information about whether the PSI could have unintended negative consequences or be under-used by pupils.

Issues relating to disclosures of personal problems.

As well as providing specifications for PSIs, the findings of the study are relevant to other aspects of school life. The following suggestions are made based on these findings.

- It is important to develop positive relationships between pupils and teachers. School staff are sometimes considered untrustworthy, contributing to an "us and them" mentality which could discourage pupils from sharing serious personal problems with adults.
- When it is safe and appropriate, confidentiality between teachers and pupils should be kept, in order to maintain positive relationships and engender trust in school staff.
- The limits of confidentiality should be made clear when pupils disclose problems to teachers. If confidentiality must be broken, pupils should be informed of who will be told and why. This should avoid any misunderstanding about the motivations of school staff listening to and sharing pupils' problems.
- Staff should respond sensitively to pupils' difficulties, to avoid reactions which adolescents might perceive as stigmatising.
- When staff are aware of a pupil experiencing a difficult problem, the role of that pupil's friends should be considered. With the pupil's permission, staff could make selected friends aware of the problem or advise them in how best to support their friend.
- As well as assisting pupils with a serious problem, staff could consider offering support to any friends to whom the problem was initially disclosed, as they may be experiencing stress and self-blame.

8.2 Implications for EPs

Pupils' mental health is a growing priority for educational settings (DoH & DfE, 2017; DoH & NHS England, 2015). As applied psychologists working at the organisational, group, and individual levels in schools (Fallon, Woods, & Rooney, 2010), EPs have a clear role in issues relating to mental health in educational contexts (Grieg, MacKay, & Ginter, 2019; Roffey, Williams, Grieg, & MacKay, 2016). A survey of EP services in Scotland found that secondary schools sought EP support for mental health at strategic levels (Grieg et al., 2019). The role of EPs in developing systemic change in schools (rather than conducting individual assessments and interventions) has received increasing attention over recent decades (Buck, 2015; Kelly, 2008; Wagner, 2008). This can involve empowering other professionals to maximise use of their skills (Kelly & Gray, 2000). EPs working systemically in schools is an impactful and effective way to improve the wellbeing of young people (Kitching, 2018).

From the findings of this study, the following implications for EPs working at a systemic level in secondary schools are suggested.

- EPs should advocate for the involvement of pupils in the design, implementation, and review of school-based interventions such as PSIs.
- EPs could direct schools towards recognising the benefits of supporting young people's mental health.
- They could introduce schools to frameworks of mental health and wellbeing other than established medical models (e.g. Keyes, 2002, 2005). Such models may broaden schools' perspectives as to how pupils' mental health can be supported in a proactive and positive way, rather than focusing on identification of diagnosable mental illnesses.
- EPs should share psychological research about adolescence as a distinct developmental period, to help schools to design interventions suitable for this age group.
- They could support schools to ensure a positive social transition from primary to secondary school.

8.3 Unique Scope and Contribution

This study took a unique perspective on the phenomenon of help-seeking and peer support between adolescents. A distinctive feature is that it took a broad view of the phenomenon, rather than focusing on one particular element. This section outlines the ways in which this study took a broader perspective than previous research, thereby highlighting its contribution to the field.

Phase 1 asked participants to consider when and how friends had approached them with problems, not when they had sought help from their friends themselves. The study thus explored adolescents' experiences of helping one another, unlike previous studies examining self-reports of help-seeking intentions (e.g. Eliot et al., 2010; Nearchou et al., 2018). Another unique feature is the exploration of peer support for "personal problems", unlike existing literature on help-seeking, which tends to examine individual problems, usually relating to mental illness (e.g. Clement et al., 2015; Gulliver et al., 2010). The study was guided by Keyes's (2002, 2005) mental health continuum as a theoretical framework, rather than the traditional medicalised perspective on mental health. As a result of these unique features, the study gave a general picture of peer support in adolescence, within a comprehensive framework of mental health.

Whilst guided by a holistic and non-medicalised framework of mental health, the design of study acknowledged the particular difficulty of supporting friends with serious problems relating to mental illness. This was reflected in the Phase 1 finding that a significant proportion of participants had struggled to help a friend with a problem relating to depression, suicidal ideation, or self-harm. The study was the first to examine English adolescents' responses to disclosures of such problems. Participants' responses were not limited to correct recognition of the diagnostic label or intended actions (as in Coles et al., 2016), but included their thoughts, words, and actions in response to the disclosure.

Phase 2 gained adolescents' views on three types of PSI. No previous studies have sought young people's opinions on the helpfulness and usability of a range of PSIs. This study therefore addressed a need identified by the *Future in Mind* report (DoH & NHS England, 2015): that the design and implementation of PSIs should be led by young people. The study identified features of PSIs which adolescents believed would improve the impact and usability of such interventions. It also demonstrated the ease and importance of gaining pupils'

views in this field: The participants were able to reflect on school-based interventions in meaningful ways, and pupils should therefore be included in the design and implementation of such systems.

The study also expanded the definition of PSIs used in other studies (e.g. Coleman et al., 2017). I considered PSIs to include any intervention which aims to help young people to support each other. As a result, universal PSIs were considered alongside organised PSIs (online and face-to-face) which are set up and monitored by adults. This expanded definition took into account the existing support networks between adolescents which were explored in Phase 1.

A limitation to the scope of the study is that a focus on peer disclosures in adolescence excludes those who do not have peers with whom to discuss problems. According to the framework of mental health guiding the study, these individuals are more likely to lack eudaimonic symptoms of mental health, including social integration and positive relations with others (Keyes, 2005). These young people may be further down the mental health continuum and therefore need support from schools. Online or face-to-face organised PSIs may help to offer the social support that these pupils need. However, this study also showed that such PSIs should be carefully implemented, guided by pupils' views.

8.4 Further Research

By taking a broad view of the phenomenon of peer support in adolescence, I aimed to identify areas which future research might examine in more detail. Potential areas for further research are outlined in this section.

Future studies might consider adolescents' responses to friends' disclosures of difficult problems other than mental illness, such as problems relating to family, relationships, friendships, and bereavement. Since this study evaluated self-reports in response to hypothetical situations, it would also be valuable to research the extent to which young people apply their knowledge to support friends with serious problems in real life.

It would be valuable to replicate Phase 1 with a representative sample of adolescents in the UK. Phase 2 could also be replicated with a broader range of pupils. This would improve the generalisability and transferability of the findings. Studies could also utilise a range of research methods to gain more depth into

some of the Phase 1 findings, such as what aspects of a friend's problem might make an adolescent decide to act, with or without the friend's permission. Adolescents' perceptions of anxiety as a mental illness also warrant further exploration: for example, why they might perceive it as less serious than other mental illnesses. This is particularly pertinent as anxiety is the most prevalent diagnosable mental illness among this age group in England (Sadler, Vizard, Ford, Marcheselli, et al., 2018).

More detailed analysis could be conducted into the role of gender in problem-sharing among adolescent peers, such as: what aspects of gender identity affect this phenomenon, whether adolescents seek support from male or female friends, and whether the genders of the discloser and disclosee affect the disclosee's response. Research could also identify factors other than gender which affect adolescents' responses to a friend with a serious problem. This information could help to target interventions for groups of young people who may need more support in this area.

More research is also needed into online disclosures of personal problems, including: differences in support sought and received online and face-to-face, differences between public and private disclosures of problems online, the implications of using particular social media platforms in this way, and gender differences in the use of technology to share problems. This study also highlights the importance of recognising social media as a platform for help-seeking and problem-sharing in adolescence. Online images of self-harm and the glamorisation of suicide on social media sites have received recent attention in the media and in parliament. The discussions often focus on the potential harm to young people who witness this content: Recommended actions highlight the responsibility of providers to prevent the promotion of such content online, for example by banning users who share these images (Savage, 2019; Wright & Javid, 2019). This perspective overlooks the possible intentions of the young people who create or share this content: They may be seeking help and support from peers. More understanding is needed about why young people share this kind of content and how adolescents who seek help in this way can be directed towards methods of help-seeking that do not disturb or harm other young people.

8.5 Concluding Comments

Research aims.

This study examined peer support for personal problems in adolescence. It sought to explore why adolescents might prefer to disclose personal problems to peers than to adults, and how adolescents support one another with such problems. It examined the role of schools in this phenomenon by gaining the views of adolescents about school-based PSIs, which are designed to help young people to support one another with problems. The intended outcome was information about how adolescents support each other with a range of personal problems that affect their mental health, and a specification of what adolescents think would make an effective and useable school-based PSI.

The study met the above aims through a combination of methodologies: a traditionally quantitative research method achieving a broad understanding of the existing phenomenon of adolescent peer support, followed by a traditionally qualitative research method seeking adolescents' in-depth views about types of school-based PSI. As a pragmatist approach was taken, the findings are not intended to be interpreted as absolute truth, but as working knowledge to help towards solving an identified problem (Section 2.6): how to improve the mental health of adolescents by helping them to support one another with personal problems. I hope that the findings will prompt future research in this field and enable secondary schools to support their pupils in ways which are informed by the views and experiences of young people.

Mental health.

This study was relevant to the field of adolescent mental health. Part of the study explored how adolescents respond to peers experiencing problems relating to mental illness. Furthermore, the study as a whole was informed by Keyes's (2002, 2005) mental health continuum. To conclude this thesis, I briefly consider the findings in the context of this framework.

The mental health continuum takes into account hedonic and eudaimonic wellbeing: They both determine where an individual lies on the mental health continuum, between languishing and flourishing (Keyes, 2002). On one level, this study is concerned with hedonic wellbeing: It considered how adolescents help

one another with problems that may cause dissatisfaction in particular domains of life. However, eudaimonia is arguably a more profound and significant measure of mental health (Keyes, 2005). The findings of this study are also relevant to a number of Keyes's (2005) positive functioning scales (given here in italics).

- Helping others with problems in a positive and non-stigmatising way is a sign of *social acceptance*.
- Supporting peers who need help may contribute to a sense of *social contribution*.
- Developing close personal relationships, in which problems can be shared in an intimate and trustworthy way, creates *positive relations with others*.
- Being able to derive comfort and support from the school community contributes to *social integration*.

Therefore, helping young people to support one another by implementing school-based PSIs transcends the aim of helping pupils to solve problems in various domains of life. If designed and implemented in ways which take into account the needs and views of the pupils for whom they are intended, PSIs may help to develop a holistic sense of wellbeing in young people at school, thereby enhancing their overall mental health.

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10. Appendices

Appendix A

Sample Questionnaire

Helping Friends with Problems

This questionnaire is about how you and your friends support one another with personal problems. There are also some questions about what you would do if a friend told you about a problem with their mental health.

- The information from these questionnaires will be used as part of my research at the University of Exeter.
- Your answers will be anonymous. If you put your name on the questionnaire, your answers will be confidential.
- The questionnaires will be stored in a secure place, and destroyed within a year.
- Information from the questionnaires will be reported anonymously.
- Please fill in this questionnaire **on your own.**
- There are no right or wrong answers. You can leave out any questions you don't want to answer.
- You can decide that you don't want me to use your questionnaire in my research any time up to a week after today (if you put your name on it).
- The subject of mental health can be upsetting. Please talk to me or a staff member if you feel upset.
- **You do not have to fill in the questionnaire if you don't want to.**

PLEASE SIGN BEFORE YOU START.
I understand the information above and am happy to take part in this research study.

Signed……..

Date…….

Gender: ……..

(I am asking about gender because there is some research saying that girls and boys might respond differently to the questions in this questionnaire. You do not have to give your gender if you don't want to.)

Part A

Lots of people go to their friends with problems: things that they are finding difficult to deal with. These questions are about times when a friend has come to talk to you about a problem that she/he is having.

1a. How often does a friend talk to you about: **a problem with a friend or group of friends** (e.g. feeling excluded, an argument with another friend)? Please tick one of the boxes below.

	Most days
	Once a week
	Once a month
	Once a year or less
	Never
	I don't know.

1b. How often does a friend talk to you about: **a problem with his/her family** (e.g. arguments at home, a problem with a parent)?

	Most days
	Once a week
	Once a month
	Once a year or less
	Never
	I don't know.

1c. How often does a friend talk to you about: **a problem with school** (e.g. teachers, exams)?

	Most days
	Once a week
	Once a month
	Once a year or less
	Never
	I don't know.

1d. How often does a friend talk to you about: **a problem with his/her mental health** (e.g. feeling anxious, stressed or depressed)?

	Most days
	Once a week
	Once a month
	Once a year or less
	Never
	I don't know.

1e. How often does a friend talk to you about: **a problem with his/her physical health** (e.g. having an illness)?

	Most days
	Once a week
	Once a month
	Once a year or less
	Never
	I don't know.

1f. How often does a friend talk to you about: **another type of problem** (please write below)?

	Most days
	Once a week
	Once a month
	Once a year or less
	Never
	I don't know.

2. Think of a time when a friend has come to you with a problem that you have found difficult to deal with. What was the problem? Please write it in the box below. Please don't give any details that might identify your friend (e.g. names).

3. When a friend comes to you with a problem, how does she/he normally do it? 'Technology' could be texting, email, or social media.

	Almost always face-to-face
	Usually face-to-face
	Equally using technology and face-to-face
	Usually using technology
	Almost always using technology
	I don't know.

4. If a friend has told you about a problem on social media, which social media platform(s) did they use (e.g. Facebook, Snapchat)?

5. Have you ever found out about a friend's problem after they posted something publically (or to all their friends) on social media (e.g. in a status update, picture or video that other people can see)?

☐ Yes ☐ No

6. If yes, which social media platform(s) did they use?

Part B

Now read the following passage. Imagine that this happened to you. Then answer the questions below.

You have been planning to go to a theme park with a few friends to celebrate your birthday. Everyone is really excited about the trip. However, one of your friends, Daniel, hasn't been so excited recently. In fact, over the past month, he hasn't seemed interested in anything, doesn't have much energy and often looks like he wants to cry. At school, the day before the trip to the theme park, Daniel takes you to one side. He says:

"I'm so sorry, but I just feel like I can't come to the theme park tomorrow. I just don't feel like it. I'm really sorry. I just feel useless and rubbish all the time. You'll have more fun without me. To be honest, I might as well be dead. No-one would care if I wasn't here anymore. Sorry I can't come."

1. *What would you **think** when you heard what Daniel said? Please tick all that apply.*

	This is a serious problem.
	Daniel has a mental health difficulty.
	I should tell an adult about this.
	I can help with solving this problem for Daniel.
	Daniel should be embarrassed about this problem.
	I'm worried about Daniel.
	Something else – please write in the box below.

2. *What would you **say** to Daniel? Please tick all that apply.*

	You shouldn't tell anyone else about this.
	I'm worried about you.
	You should tell an adult about this.
	I won't tell anyone about this if you don't want me to.
	You're still my friend.
	We can solve this problem by ourselves.
	I can't help you with this problem.
	Tell me more about how you're feeling.
	Have you been thinking about suicide?
	Something else - please write in the box on the next page.

3. *How confident do you feel that you have **said** the right thing to Daniel? Please circle a number.*

Not at all confident Very confident

0 1 2 3 4 5 6 7 8 9 10

4a. *Would you **do** something about Daniel's problem, e.g. tell an adult?*

	No.
	Yes, but only if Daniel agreed that I could.
	Yes, even if Daniel did not want me to.

4b. *If you answered 'yes', what would you do?*

5. *You may have chosen to do something about Daniel's problem, or to do nothing. Either way, how confident do you feel that you have chosen the right action? Please circle a number.*

Not at all confident Very confident

0 1 2 3 4 5 6 7 8 9 10

Now read the following passage. Imagine that this happened to you. Then answer the questions below.

Your friend, Zain, hasn't been in school all week. You text him to ask if you can come over to his house to see him, and he replies saying yes. When you get to his house, he explains:

"I've just been feeling so worried about everything lately. We had that exam on Monday, and I barely slept all of Sunday night. Then I just couldn't bring myself to come into school. All these horrible thoughts are just running through my head all the time. I haven't been sleeping properly. I've felt like this for a while, but now it's just out of control. I've been telling my mum that I'm feeling ill which is why she's let me stay off school. I don't know what to do."

1. *What would you **think** when you heard what Zain said? Please tick all that apply.*

	This is a serious problem.
	Zain has a mental health difficulty.
	I should tell an adult about this.
	I can help with solving this problem for Zain.
	Zain should be embarrassed about this problem.
	I'm worried about Zain.
	Something else – please write in the box below.

2. *What would you **say** to Zain? Please tick all that apply.*

	You shouldn't tell anyone else about this.
	I'm worried about you.
	You should tell an adult about this.
	I won't tell anyone about this if you don't want me to.
	You're still my friend.
	We can solve this problem by ourselves.
	I can't help you with this problem.
	Tell me more about how you're feeling.
	Have you been thinking about suicide?
	Something else - please write in the box below.

3. *How confident do you feel that you have **said** the right thing to Zain? Please circle a number.*

Not at all confident Very confident

0 1 2 3 4 5 6 7 8 9 10

4a. *Would you **do** something about Zain's problem, e.g. tell an adult?*

	No.
	Yes, but only if Zain agreed that I could.
	Yes, even if Zain did not want me to.

4b. *If you answered 'yes', what would you do?*

5. *You may have chosen to do something about Zain's problem, or to do nothing. Either way, how confident do you feel that you have chosen the right action? Please circle a number.*

Not at all confident Very confident

0 1 2 3 4 5 6 7 8 9 10

END OF QUESTIONNAIRE

I hope that you didn't find anything in the questionnaire upsetting. If you did, please talk to me or to a staff member. You can also call Childline at 0800 1111 or visit their website for support.

If you would like me to send you a summary of the findings from this study, please write your email address here:

…….

Thank you for taking part in this research.

Appendix B

Vignettes in Questionnaires

Depression Vignette

You have been planning to go to a theme park with a few friends to celebrate your birthday. Everyone is really excited about the trip. However, one of your friends, Daniel, hasn't been so excited recently. In fact, over the past month, he hasn't seemed interested in anything, doesn't have much energy and often looks like he wants to cry. At school, the day before the trip to the theme park, Daniel takes you to one side. He says:

"I'm so sorry, but I just feel like I can't come to the theme park tomorrow. I just don't feel like it. I'm really sorry. I just feel useless and rubbish all the time. You'll have more fun without me. To be honest, I might as well be dead. No-one would care if I wasn't here anymore. Sorry I can't come."

Adapted from the Friend in Need Questionnaire vignette (Burns & Rapee, 2006, pp. 236-237):

> Emily is in Year 12. She and her friend, Amy, have been planning to go away together for Schoolies Week on a Cruise with a group of other girls and boys from their local area. Amy and Emily had been planning their Schoolies trip since Emily's older sister had finished her HSC 2 years ago and gone to Schoolies at the Gold Coast. Lately, however, Amy had noticed that Emily hadn't been so excited about the trip – in fact, she had noticed that over the past month, or maybe longer, Emily hadn't been very interested in anything very much, had lost her characteristic spark and energy, and regularly appeared to be sad and tearful. To make matters worse, Emily had forgotten to call the travel agent on the allocated day to confirm their tickets, and had cost them both an extra $50 in failed 'confirmation fees'. Emily was very apologetic to Amy, but nothing Amy said seemed to cheer Emily up. Emily just kept saying that she was 'useless' and 'good for nothing', and that 'she might as well just be dead because no-one would care if she wasn't here any more.'

Anxiety Vignette

Your friend, Zain, hasn't been in school all week. You text him to ask if you can come over to his house to see him, and he replies saying yes. When you get to his house, he explains:

"I've just been feeling so worried about everything lately. We had that exam on Monday, and I barely slept all of Sunday night. Then I just couldn't bring myself to come into school. All these horrible thoughts are just running through my head all the time. I haven't been sleeping properly. I've felt like this for a while, but now it's just out of control. I've been telling my mum that I'm feeling ill which is why she's let me stay off school. I don't know what to do."

Self-Harm Vignette

One of your friends, Zain, is having a hard time. He hasn't done very well in his mock GCSE exams at school, and his girlfriend recently broke up with him. He has been posting pictures and messages on social media about feeling sad and lonely. One day, you see that he has posted a picture on Instagram of some cuts on his arm. His comment and hashtags beneath the picture suggest that he has cut himself. You ask him about it the next day at school, and he tells you that he has been self-harming.

NB: Questionnaires were counterbalanced for gender. Female vignette-characters were also used (Ayesha and Anna).

Appendix C

Focus Group Schedule

Personal Experiences

1. Personal experiences of being helped by a peer

Think of a time when a friend helped you with a problem.

What made the friend help you (e.g. did you ask for help)?

What did they do to help you?

What was it like receiving that help?

How was it different to seeking help from an adult?

Why did you get help from a friend rather than an adult?

2. Peer support schemes at school

Can you think of any scheme or programme at school which has helped young people to help each other? (e.g. buddy or mentor schemes etc.)

Did it help? What was helpful?

(Primary school if none in secondary – would it work in secondary?)

Evaluation of PSIs

Organised peer support: Adults creating a system in which young people help each other, e.g. training mentors or buddies that you can go to with a problem.

Have you heard of or been involved in this kind of programme before?

What might be some of the benefits of this kind of programme?

Who might it be most helpful for?

Is there anyone this kind of programme might not be helpful for?

What are some of the downsides to this kind of programme?

Would you take part in this kind of programme – being trained as a 'buddy' or going to a 'buddy' with a problem?

MATRIX ACTIVITY

Sometimes these programmes are run **online**, e.g. an online forum set up by adults, where trained young people answer questions and provide help.

What might be some of the benefits of this kind of online programme?

Who might it be most helpful for?

What are some of the downsides to this kind of online programme?

Would you take part in this kind of programme – being trained as an 'online buddy' or using an online forum set up by adults to help you with a problem?

Does it matter if it is anonymous?

Does it matter if it is just within the school/year group, or open?

MATRIX ACTIVITY

Universal programmes for peer support: All young people being prepared by adults to improve the support they give to their friends, e.g. young people being trained in how to help a friend with a serious problem (e.g. mental health difficulty).

Have you heard of or been involved in this kind of programme before?

What might be some of the benefits of this kind of programme?

Who might it be most helpful for?

Is there anyone this kind of programme might not be helpful for?

What are some of the downsides to this kind of programme?

If you had training like this, do you think you would use it to help your friends with their problems?

MATRIX ACTIVITY

Appendix D

PSI-type Drawings for Focus Groups

Figures D1-D3 are the cartoon-style drawings that I made, to help explain each PSI-type to participants in the focus groups.

Figure D1
Organised PSI drawing

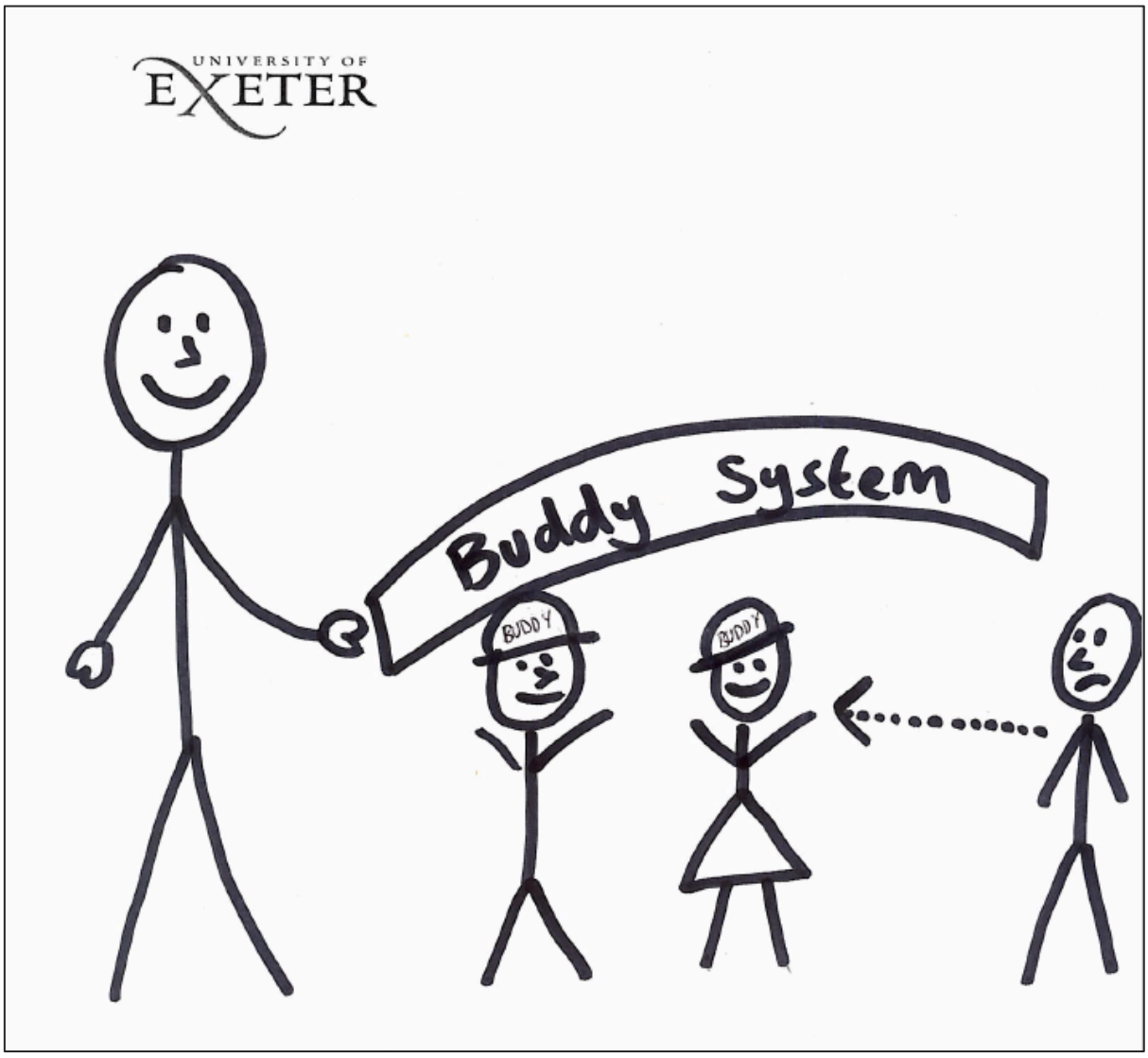
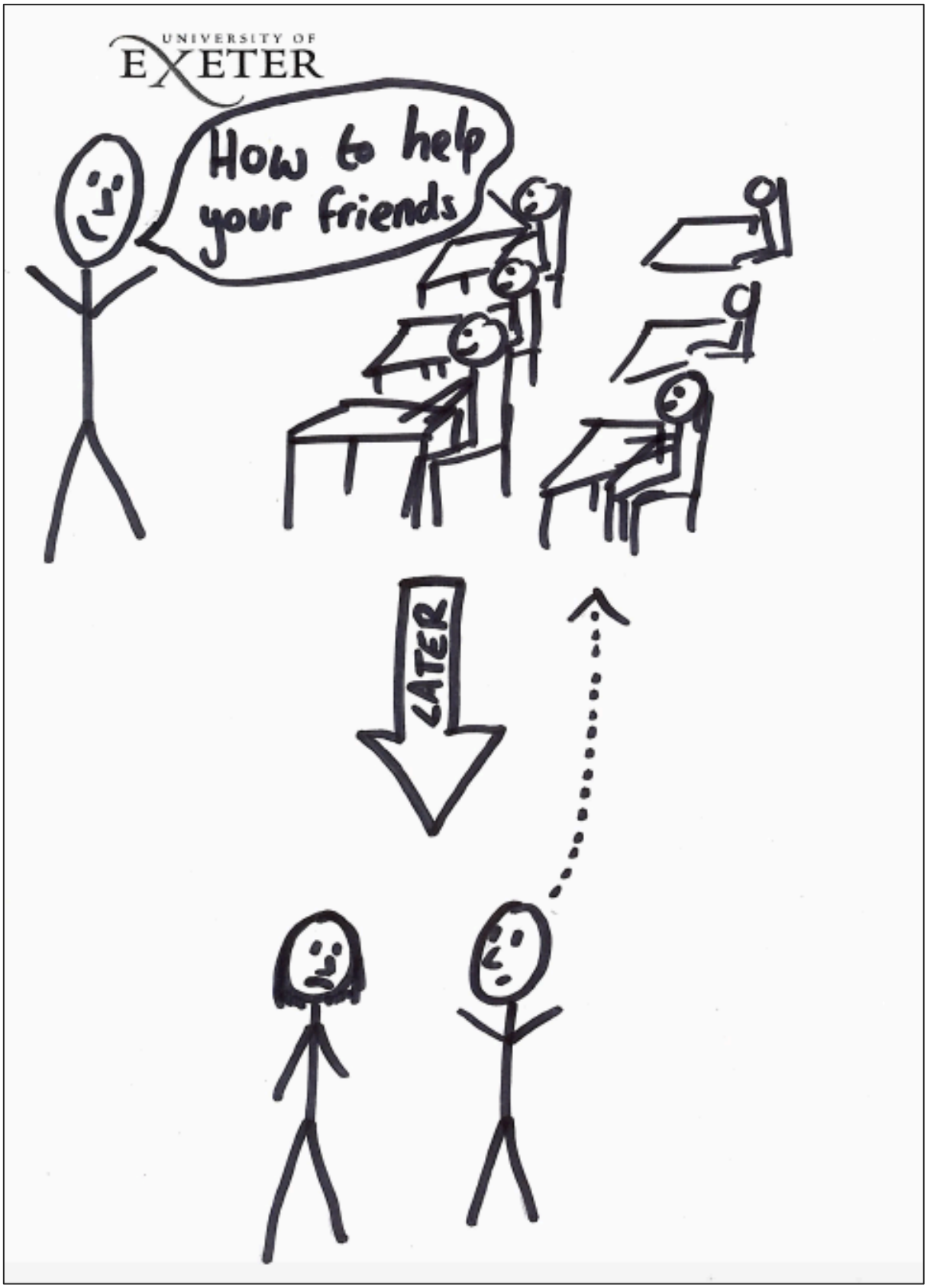


Figure D2
Online PSI drawing

Figure D3
Universal PSI drawing



Appendix E

Senior Leadership Team Information and Consent Letter

Peer Support for Mental Health and Wellbeing in Secondary Schools

Research has shown that when young people experience difficulties in their lives, they often choose to discuss these issues with their friends and peers. This project aims to explore:

- young people's experiences of discussing issues affecting wellbeing and mental health with their friends;
- how confident young people feel in responding to friends' disclosures of problems relating to mental health and wellbeing;
- and how young people can be supported to help one another more effectively.

The research will take part in two phases.

Phase 1: Questionnaires

- I will provide you with paper questionnaires to be distributed to your Year 9 cohort. I will be present for the administration of the questionnaires, through arrangement with the school.
- The questionnaires will ask questions about the students' experiences of peers discussing a personal problem with them.
- Two (of a possible three) scenarios will then be presented to the participants, in which a friend discloses a personal problem relating to mental health. The participant will be asked what they would think, say and do in response to the disclosure.

Phase 2: Focus groups

- Please select twelve students for Phase 2. There should be an equal number of males and females, and there should be a range of academic ability. Active parental consent will be gained by letter.

- Each focus group will include six students and last no longer than 1 lesson.
- In the focus group, students will be asked to give their views about certain types of existing formal peer support interventions, and to discuss what kind of intervention might support them best.

Following your participation, you will receive:

- An anonymised summary of the questionnaire and focus group findings. This will be a combination of findings across all participating schools.
- Information to inform the development of a future peer support intervention which you may choose to implement in your school.

Next Steps:

- If you would like to participate, I will arrange a visit to the school to discuss arrangements and answer any further questions, or arrangements can be made by email or phone.
- I will supply a template letter to be distributed to parents/carers of Year 9 students. This will contain information about the study and ask parents to contact the school if they do not wish their child to take part in Phase 1 (questionnaire). This is in line with GDPR. You are free to administer the letter how you wish.

Further Information

Purpose of Study

This research is taking place for a thesis as part of my completion of the Child, Community and Educational Psychology Doctorate (DEdPsy) at the University of Exeter. The findings will be used as part of this doctoral thesis, and may be used at conference presentations and for publication in an academic journal. The study has received the relevant ethical approval.

Voluntary Participation

Passive parental consent must be gained prior to the student's participation in Phase 1 of the study: i.e. parents must contact the school or researcher if they do not want their child to take part. This is in line with GDPR. Active parental consent must be gained prior to selected students' participation in Phase 2. Regardless of parental consent, the students' participation in either phase of the study is voluntary. Students can withdraw from the study at any time up to one week after the administration of the focus groups.

Data Protection

The questionnaires will be anonymous, meaning the data is not covered by GDPR. Responses given in the focus groups will be confidential, unless there is a safeguarding concern, which will be shared with the school's safeguarding lead. Paper questionnaires will be accessible only the researcher and stored in a locked cabinet. They will be destroyed within two years.

Focus groups will be recorded using a computer programme. Audio files will be stored on a password-protected computer, and deleted within one year. Transcriptions will not contain names or identifiable information. All data will be reported anonymously.

Assessment of Possible Harm

Every effort has been made to ensure that the contents of the questionnaire and focus groups do not cause undue distress to students. However, since this study is concerned with mental health, it is possible that some students may become distressed as a result of the content of the study. The following measures will be taken to address this:

- All staff working with Year 9 should be informed of the nature of the study on the day of the questionnaire/focus group administration.
- I will discuss with the link member of staff (e.g. SENCo) whether any individual students may experience distress due to the content of the study.

- A member of staff will be designated as a key contact for students who wish to talk to somebody following their participation in the study.
- School staff should report any instances of distress subsequent to the study to me, so that I can provide any necessary advice and support (in my capacity as a Trainee Educational Psychologist with the --- Educational Psychology Service).

I would be glad to answer any further questions about this project. Please contact me at [email omitted]. You can also contact one of my supervisors at the university: Professor Brahm Norwich [email omitted] and Margie Tunbridge [email omitted].

Consent Agreement

I have read about the Peer Support for Mental Health project and understand the basis for our involvement. I consent to take part. I understand that I can withdraw from this study at any time:

For head teacher or member of senior leadership team to sign:

Name:……

Role:……

Signature:……

Date:……

Appendix F

Phase 1 Parental Information and Consent Letter

Dear Parent/Guardian,

Your child has been invited to take part in a study about how young people support each other with problems about mental health. This will involve completing a questionnaire which explores how young people might respond to a friend telling them about wellbeing and mental health difficulties.

Why is this research happening?

This research is taking place across a number of secondary schools in [local authority]. The findings of the study will be part of a doctoral thesis (Doctorate in Child, Community and Educational Psychology). However they may also be useful to the schools involved and be communicated through conference presentations and published in a journal. I am being supervised by experienced researchers at the University of Exeter.

Why has my child been selected?

All children in Year 9 at the school have been invited to take part in this study.

Taking part is voluntary

Your child's participation in this study is completely voluntary, and he/she can withdraw at any time before he/she hands in the completed questionnaire.

What if my child gets upset?

I have worked hard to make sure that the contents of the questionnaire and focus groups do not upset the children who take part. The problems talked about in the questionnaire are fairly common and are likely to be familiar to your child. The questionnaire contains short descriptions of depression, anxiety and self-harm. Measures will be taken within the school to ensure that any children who become

upset are given the right level of support. If you would like more information about these measures, please contact me.

Data Protection

Your child's name will not be written on the questionnaire, so the data is anonymous. It is therefore not covered by GDPR.

The information provided will be used for research purposes and personal data will be processed in accordance with current data protection legislation and the University's notification lodged at the Information Commissioner's Office. Personal data will be treated in the strictest confidence and will not be disclosed to any unauthorised third parties. The results of the research will be published in anonymised form.

What if I do not want my child to take part?

If you do **not** want your child to take part in the questionnaire, please complete the slip below and return to your child's form teacher. Please do this before [date of administration].

IF YOU ARE HAPPY FOR YOUR CHILD TO TAKE PART IN THE QUESTIONNAIRE, YOU DO NOT NEED TO DO ANYTHING.

If you have any questions or concerns about this study, please email me at [email omitted] or one of my supervisors: Professor Brahm Norwich at [email omitted] or Margie Tunbridge at [email omitted].

I would **not** like my child to take part in the Peer Support for Mental Health study.

Name of child: …….

Parent signature: ……..

Date: ……

Please give this slip to your form teacher by [date of administration], who will pass it on to the school SENCo.

Appendix G

Phase 1 Participant Assent Form

This assent form was used as a separate sheet instead of the front page of the questionnaire, after the implementation of GDPR.

PLEASE SIGN THIS SHEET BEFORE YOU START.

DO NOT WRITE YOUR NAME ON THE QUESTIONNAIRE.

This questionnaire is about how you and your friends support one another with personal problems. There are also some questions about what you would do if a friend told you about a problem with their mental health.

- The information from these questionnaires will be used as part of my research at the University of Exeter.
- Your answers will be anonymous. You must not write your name or email address on the questionnaire.
- The questionnaires will be stored in a secure place, and destroyed within a year.
- Information from the questionnaires will be reported anonymously.
- Please fill in this questionnaire **on your own.**
- There are no right or wrong answers. You can leave out any questions you don't want to answer.
- The subject of mental health can be upsetting. Please talk to me or a staff member if you feel upset.
- **You do not have to fill in the questionnaire if you don't want to.**

PLEASE SIGN BEFORE YOU START.

I understand the information above and am happy to take part in this research study.

Signed……..

Date……..

If you would like me to send you a summary of the findings from this study, please write your email address here:

…….

Appendix H

Phase 2 Parental Information and Consent Letter

Dear Parent/Guardian,

Your child has been invited to take part in the second part of a study about how young people support each other with problems about their mental health and wellbeing. This involves a group interview about peer support interventions (programmes at school which help young people to support each other). It is important to get the views of young people on what they would find most helpful. I hope that this study will help people to design future interventions to help young people support one another with their mental health and wellbeing.

Please read the information below and **return the slip** to give permission for your child to take part in this group interview.

Why is this research happening?

This research is taking place across a number of secondary schools in [local authority]. The findings of the study are part of a doctoral thesis (Doctorate in Child, Community and Educational Psychology). However they may also be useful to the schools involved and be communicated through conference presentations and published in a journal. I am being supervised by experienced researchers at the University of Exeter.

Why has my child been selected?

A number of children in Year 9 have been selected by the SENCO. The researcher asked the SENCO to select children of both genders, and children with a range of academic abilities. Parents must give permission for their child to take part.

Taking part is voluntary

The study is completely voluntary, and your child can withdraw at any time up to one week after the administration of the group interviews. Complete withdrawal

may not be possible due to the difficulty of identifying individual participants on the recording.

Are there any risks?

It is very unlikely that your child will become upset during the group interview. The interview is focused on school interventions, and participants will not be asked to talk about their own experiences of mental health difficulties. In the unlikely event that your child becomes upset, measures will be taken at school to ensure that he/she receives the right level of support. If you would like more information about these measures, please contact me.

Data Protection

The group interviews will be audio-recorded and stored on a password-protected computer. Transcripts will be made, and will not contain any information that might identify your child. Recordings will be deleted within two years. All members of the group will be asked to keep the content of the interview confidential. If your child says something that makes me concerned for his/her safety or the safety of others, I will need to report it to a member of staff at school.

The information provided will be used for research purposes and personal data will be processed in accordance with current data protection legislation and the University's notification lodged at the Information Commissioner's Office. Personal data will be treated in the strictest confidence and will not be disclosed to any unauthorised third parties. The results of the research will be published in anonymised form.

IF YOU ARE HAPPY FOR YOUR CHILD TO TAKE PART, PLEASE RETURN THE SLIP BELOW BY [date].

If you are happy for your child to take part in the group interview, please complete the slip below and return to [staff member]. Or you can email me directly to say that you are happy for your child to take part. Please do this by [date of administration].

If you have any questions or concerns about this study, please email me (Finola Holyoak) at [email omitted] or one of my supervisors: Professor Brahm Norwich at [email omitted] or Margie Tunbridge at [email omitted].

I give permission for my child to take part in Phase 2 of the Peer Support for Mental Health study.

Name of child: ……..

Parent signature: ……

Date: ……..

Please give this slip to [staff member] by [date of administration].

Appendix I

Phase 2 Participant Assent and Confidentiality Agreement

Consent and Confidentiality Agreement

- What you say in this group interview will be used as part of research at the University of Exeter.
- The researcher will keep everything you say in this group interview confidential, unless you say something that suggests that someone is in danger.
- This group interview will be recorded on a computer. The recordings will be deleted within two years.
- The researcher will write down everything that is said in this group interview. No information will be written down that might identify the people in this group.
- You can decide that you don't want the researcher to use what you say in this group interview any time up to a week after today. It might not be possible to remove everything that you said from the final research.
- The subject of mental health can be upsetting. Please talk to me or [identified staff member] if you feel upset.
- **You do not have to take part in this group interview if you don't want to.**

Please sign.

I understand what this research is about and I am happy to take part. I understand how my information will be used. I understand that I do not have to take part in this research if I don't want to, and that I can withdraw at any time up to a week after today.

I agree not to tell anybody anything discussed during this focus group. I understand that the researcher will have to tell [staff member] if I say something that suggests that I or somebody else is in danger.

Signed: ……

Date: ……

Appendix J

Phase 1 Findings: Full Frequency Tables

This appendix contains the full frequency tables for the Phase 1 findings which were not included in the main body of the thesis.

'Other' Problems

Participants were given an open-ended question to state a problem-type that they discussed with friends, which were not given in previous questions. Responses were analysed using content analysis (Section 3.6). Table J1 displays all responses to this question. It displays the frequency of male (*n* = 52), female (*n* = 84), and no-gender (*n* = 11) respondents who gave each response.

Table J1
Full frequency table: other problem-types disclosed by peers

Problem	Male	Female	No-gen	Total
Relationships	19	20	2	41
School stress	8	7	0	15
Friendships	4	10	0	14
Bullying	4	7	1	12
Depression/Self-Harm/Stressed	2	8	1	11
Anxiety/Confidence	0	9	1	10
Vague response	3	6	1	10
Appearance	3	2	1	6
Family/Home	3	3	0	6
Social media/Gaming	3	3	0	6
Illness	1	3	1	5
"It's private"	0	3	1	4
Anger/Violence	1	0	2	3
Money	0	3	0	3
Sports	1	0	0	1

Difficult Problems

Participants were asked to think of a time when a friend came to them with a problem that they found difficult to deal with. Responses were analysed using basic content analysis. Participants could give more than one response: There were 92 responses given by 87 male participants, 144 responses given by 132 female respondents, and 8 responses given by 8 no-gender respondents. Table J2 displays the frequencies of all responses to this question, by gender.

Table J2
Full frequency table: problems which are difficult to help a peer with

Code	Male	Female	No-gen	Total
Family	23	43	2	68
Depression/Self-harm/Suicidal	13	31	0	44
Friendships	8	20	1	29
Relationships	11	18	0	29
Bereavement/Serious illness	8	12	1	21
Bullying	8	2	0	10
Anxiety/Confidence	3	4	0	7
School/Exams	4	3	0	7
Illness	3	2	0	5
Vague response	1	2	2	5
Abused/Neglected	2	2	0	4
Violence	2	0	2	4
Anorexia/Food	1	2	0	3
“It’s private”	2	0	0	2
Sexuality	0	2	0	2
Sleep	1	1	0	2
Appearance	1	0	0	1
Committed a crime	1	0	0	1

Social Media: Disclosures

Participants were asked on which social media platform(s) they had received a disclosure of a problem from a friend. Participants could give more than one response: There were 176 responses given by 126 male respondents, 231 responses given by 158 female respondents, and 35 responses given by 19 no-gender respondents. Table J3 displays the frequencies of all responses to this question, by gender.

Table J3
Full frequency table: social media platforms used to share problems

Response	Male	Female	No-gen	Total
Snapchat	67	116	11	194
Instagram	43	63	14	120
Facebook	23	18	4	45
Messenger	20	10	0	30
WhatsApp	7	17	0	24
Gaming	9	0	3	12
Other private calls/messages	3	5	1	9
Other social networking sites	1	2	0	3
Micro-blogging	1	0	1	2
Media-sharing	2	0	0	2
Dating apps	0	0	1	1

Social Media: Public

Participants were then asked which social media platform(s) their friends had used to share a problem publicly. Participants could give more than one response: There were 92 responses given by 75 male respondents, 135 responses given by 112 female respondents, and 11 responses given by 10 no-gender respondents. Responses were analysed using content analysis. Table J4 displays the frequencies of all responses to this question, by gender.

Table J4
Full frequency table: social media platforms used to share problems publicly

Response	Male	Female	No-gen	Total
Snapchat	44	78	6	128
Instagram	29	38	3	70
Facebook	14	14	2	30
Other	5	5	0	10

Vignette Responses: All Code Frequencies

Open questions allowed participants to give answers that had not been covered in the multiple-choice options when asked what they would think and say in response to the disclosure in the vignettes. If participants stated that they would do something about the character's problem, they were also given an open question asking what action they would take. The answers to these three open

questions were combined to establish participants' overall response to the vignettes. The responses were analysed using basic content analysis (Section 3.6). Table J5 displays the full list of codes that emerged during the content analysis. Tables J6-J8 display the frequency of each code given in response to each vignette, by gender.

Table J5
Vignette responses content analysis: code names key

Code	Descriptor
Be	Be there for him/her
Cau	Speculation about cause of problem
Conf	Keep it confidential (even if telling adult)
Dis	Discourage the activity
Emo	Emotional reaction
Enc	Give encouragement/confidence
Expl	Explore the problem
Fam	Tell his/her family member
Feel	Ask after feelings
Fri	Speak to his/her friends
Gow	Go with him/her to get help
Help	I want to/can help him/her
Hide	Hide it / Don't tell anyone
MFa	Tell my family member
Need	He/She needs to get help (not from me)
Neg	Negative/dismissive statements
No	I can't help
Ok	Get permission to tell
Onl	Seek online help
Prac	Offer practical help
Prof	Seek professional help
Sch	Tell a member of school staff
Sui	Suicide risk
Talk	She/He needs to talk to someone else
UnAd	Tell an (unidentified) adult
Unc	Unclear answer
Und	Show understanding
UnSO	Tell (unidentified) someone
Wors	Could get worse / Act if it gets worse
Xad	Adults can't help

Table J6

Depression vignette: all code frequencies by gender

Code	Male	Female	No-gen	Total
UnAd	3	42	4	49
Talk	28	8	2	38
Expl	20	10	3	33
Sch	10	22	1	33
Fam	3	22	0	25
Enc	7	14	3	24
Gow	11	8	0	19
Und	18	1	0	19
Help	1	15	0	16
Emo	12	2	0	14
Feel	6	7	0	13
Be	6	6	1	13
UnSO	2	11	0	13
Prof	9	3	0	12
Need	2	7	0	9
Mfa	5	2	0	7
Prac	6	0	0	6
Sui	1	3	1	5
Cau	3	1	0	4
Dis	4	0	0	4
Ok	3	1	0	4
Unc	2	2	0	4
Fri	2	1	0	3
Hide	2	0	0	2
No	1	0	1	2
Wors	0	2	0	2
Conf	1	0	0	1
Xad	0	1	0	1

Table J7

Anxiety vignette: all code frequencies by gender

Code	Male	Female	No-gen	Total
UnAd	29	45	1	75
UnSO	17	26	1	44
Fam	16	22	1	39
Talk	7	21	1	29
Help	7	12	3	22
Sch	7	9	2	18
Enc	7	9	0	16
Cau	8	2	0	10
Dis	6	1	2	9
Feel	0	6	1	7
Expl	5	1	1	7
Neg	4	2	0	6
Prac	2	4	0	6
Prof	4	2	0	6
Conf	2	3	0	5
Need	3	2	0	5
Ok	0	1	4	5
Wors	1	4	0	5
Onl	1	3	0	4
Gow	3	0	0	3
Mfa	1	2	0	3
No	0	3	0	3
Emo	1	1	0	2
Fri	2	0	0	2
Und	1	1	0	2
Be	0	1	0	1
Hide	1	0	0	1
Unc	0	1	0	1
Xad	0	1	0	1

Table J8

Self-harm vignette: all code frequencies by gender

Code	Male	Female	No-gen	Total
UnAd	28	45	5	78
UnSO	18	22	3	43
Fam	18	11	2	31
Help	8	19	2	29
Expl	4	18	2	24
Sch	12	10	1	23
Enc	6	12	3	21
Talk	3	15	2	20
Need	2	9	2	13
Dis	7	5	0	12
Be	3	5	1	9
Prof	4	3	1	8
Wors	2	6	0	8
Neg	4	2	1	7
Emo	3	3	0	6
Gow	1	5	0	6
Ok	0	4	2	6
Prac	4	1	0	5
Conf	1	3	0	4
Mfa	2	1	0	3
Feel	0	2	0	2
Hide	1	1	0	2
Sui	1	0	1	2
Unc	1	1	0	2
Cau	0	1	0	1
Fri	1	0	0	1
Onl	0	1	0	1
Und	1	0	0	1

Vignette Responses: Code Frequencies as Presented in Section 4.4

The findings presented in Section 4.4 are a summary of the results of the content analysis. Codes were combined into groups under three overarching headings: “How to react?”, “What to do?”, and “Whom to tell?”.

Heading 1: How to react?

Tables J9-J11 display the frequencies of male, female, and no-gender respondents who gave each answer under the heading “How to react?”.

Table J9
Full frequency table by gender for depression vignette: How to react?

Code group	Male	Female	No-gen	Total
Be a friend	31	21	4	56
Find out more	26	17	3	46
Could get worse	1	5	1	7
Discourage	4	0	0	4
Negative	0	0	0	0

Table J10
Full frequency table by gender for anxiety vignette: How to react?

Code group	Male	Female	No-gen	Total
Be a friend	8	11	0	19
Find out more	5	7	2	14
Discourage	6	1	2	9
Negative	4	2	0	6
Could get worse	1	4	0	5

Table J11
Full frequency table by gender for self-harm vignette: How to react?

Code group	Male	Female	No-gen	Total
Be a friend	10	17	4	31
Find out more	4	20	2	26
Discourage	7	5	0	12
Could get worse	3	6	1	10
Negative	4	2	1	7

Heading 2: What to do?

Tables J12-J14 display the frequencies of male, female, and no-gender respondents who gave each answer under the heading “What to do?”.

Table J12
Full frequency table by gender for depression vignette: What to do?

Code Group	Male	Female	No-gen	Total
Tell someone (vague)	5	53	4	62
He/She needs help	30	15	2	47
Accompany	11	8	0	19
I can help	1	15	0	16
Offer practical help	9	3	0	12
Confidential	1	0	0	1

Table J13
Full frequency table by gender for anxiety vignette: What to do?

Code Group	Male	Female	No-gen	Total
Tell someone (vague)	46	71	2	119
He/She needs help	10	23	1	34
I can help	7	12	3	22
Offer practical help	2	4	0	6
Confidential	2	3	0	5
Accompany	3	0	0	3

Table J14
Full frequency table by gender for self-harm vignette: What to do?

Code Group	Male	Female	No-gen	Total
Tell someone (vague)	46	67	8	121
He/She needs help	5	24	4	33
I can help	8	19	2	29
Accompany	1	5	0	6
Offer practical help	4	1	0	5
Confidential	1	3	0	4

Heading 3: Whom to tell?

Tables J15-J17 display the frequencies of male, female, and no-gender respondents who gave each answer under the heading “Whom to tell?”.

Table J15

Full frequency table by gender for depression vignette: Whom to tell?

Code Group	Male	Female	No-gen	Total
Tell school	10	22	1	33
Tell family	8	24	0	32
Tell professional	9	3	0	12
Tell friends	2	1	0	3
Find help online	0	0	0	0

Table J16

Full frequency table by gender for anxiety vignette: Whom to tell?

Code Group	Male	Female	No-gen	Total
Tell family	17	24	1	42
Tell school	7	9	2	18
Tell professional	4	2	0	6
Find help online	1	3	0	4
Tell friends	2	0	0	2

Table J17

Full frequency table by gender for self-harm vignette: Whom to tell?

Code Group	Male	Female	No-gen	Total
Tell family	20	12	2	34
Tell school	12	10	1	23
Tell professional	4	1	0	5
Tell friends	1	0	0	1
Find help online	0	1	0	1

Appendix K

Content Analysis: Working Lists of Codes

During basic content analysis, I kept notes about which answers were categorised under which codes, in order to ensure consistency throughout the process. Table K1 displays the working list of codes for the open question inviting participants to list a problem they discuss with friends which was not included in the previous questions. Table K2 displays the working list of codes for the open question asking participants to give a problem which they had found difficult to support a friend with.

Table K1
Working list of codes: other problem-types disclosed by peers

Code	Descriptor
Ang	Anger/Violence/Fights
Anx	Anxiety/Worry/Confidence
App	Appearance/Weight
Bul	Bullying (incl. homophobia)
Dep	Depression/Self-harm/Upset/Stressed
Fam	Family problems/Home problems
Fnd	Friendships/Other people/Popularity
Ill	Illness/Physical health
Mon	Money
Pri	Private
Pub	Puberty
Rel	Relationships
Sch	School stress/Homework
SM	Social media/Online/Video games
Spt	Sport
Vag	Vague reference to ‘problems’

Table K2

Working list of codes: problems which are difficult to help a peer with

Code	Descriptor
Abu	Abused/Unloved/Neglected
Ano	Food/Anorexia
Anx	Anxiety/Confidence/Stress
App	Appearance
Ber	Loss/Bereavement/Serious illness (of someone else)
Bul	Bullying
Cri	Committed a crime
Dep	Depression/Self-harm/Suicidal/Mood
Fam	Home/Family problems
Fnd	Friendships/ Popularity
Med	Medical/Injury/Illness
Pri	Private
Rel	Relationships
Sch	School/teachers/exams
Sex	Sexuality
Slp	Sleep
Vag	Vague reference to ‘problems’
Vio	Violence/Fights

Tables K3-K5 display the working list of codes for the open questions relating to participants' responses to the questionnaire vignettes. They were divided into broad themes at this stage: "Feelings and talking," "Telling people," and "Other."

Table K3

Working list of codes: vignette responses relating to feelings and talking

Code	Descriptor	Example responses
Feel	Ask after feelings	Ask how she feels Ask when she started feeling like this Question why he feels like this What's been on your mind? Are you comfortable opening up to me? Are you ok?
Expl	Explore the problem	Help her by getting to bottom of it Talk to him more about it Ask for more details Why did you do it? What caused these emotions? Ask them if they would do it Explain the problem
Be	Be there for him/her	I need to be there for them I'm here if you need it Stick by her side Talk to her every day Spend more time with her I need to look out for him Be a good friend Make sure she is safe I won't go to the theme park myself
Enc	Give encouragement or build confidence	Tell her how important she is Boost her confidence Talk about the positives Make her feel good about herself Don't worry Comfort him Give her support Help him find coping mechanisms I should support him This trip will make you feel better Tell him to talk to me when he does it
Und	Show understanding	Tell her I understand There's no need to hide it Same to be honest Don't be embarrassed

Neg	Negative or dismissive statements	Have a go at her for being stupid Stop being so stupid I don't care This isn't something to worry about You're attention seeking This isn't serious Calm down
Dis	Discourage the activity	Please stop You shouldn't think about that Tell him to go to school Force her to do the exams Put him off harm
Emo	Emotional reaction	I would feel shocked Feel sorry for him I want her to be happy/safe This isn't right She's broke This is serious He's not thinking straight
Hide	Hide it / Don't tell anyone	How are you going to cover it up? He won't tell anyone
Cau	Speculation about cause of problem	She is stressed about exams Bullying She is stressing over something It's a cry for help Mental health problem She needs more sleep He is having problems
No	I can't help	There isn't much I can do She should think how to solve this. I haven't experienced this problem

Table K4

Working list of codes: vignette responses relating to telling people

Code	Descriptor	Example responses
XAd	Adults can't help	Adult might not be able to help Only tell adult as a last resort
UnAd	Tell an (unidentified) adult	Tell an adult Tell an adult we trust See if it is worth telling an adult Ask an adult for advice
Sch	Tell a member of school staff	Tell a safeguarding teacher Tell a teacher
Talk	S/he needs to talk to/see someone else	Needs to talk about it with s/o she trusts You need to tell an adult or close friend Convince her to tell an adult She should see someone I think you should tell someone Have you told anyone else? If you don't tell anyone it could be bad Ask him to talk to his parents Try to get help by your parents
Ok	Get permission to tell	Ask if it was ok to tell someone Wait until he's ready to tell someone Ask him if he wants me to tell our mates
Gow	Go with him/her to get help	Go with him to tell someone Go with him to tell an adult Ask him to come with me Bring her with me to tell someone Go with him [to tell specified adult]
UnSO	Tell (unidentified) someone	Tell someone to get real advice Tell someone Tell someone she trusts Ask for advice So someone can help him
Fam	Tell his/her family member	Tell her parent
Prof	Seek professional help	Tell Childline Tell a professional Get him online support Ask a doctor Tell him to find professional advice
Onl	Seek online help	
MFa	Tell my family member	Talk to my parents
Fri	Speak to his friends	

Table K5

Working list of codes: other vignette responses

Code	Descriptor	Example responses
Help	I want to/can help her	I could help her Help him myself Try to fix the problem Try and help them Try to solve it ourselves I should help you I should take care of you We can try and help this Help him find coping mechanisms Give her advice Is there anything I can do? Do whatever works
Prac	Offer practical help	Help with the exam/revise Take everything that could harm him Put plasters on his cuts Ask a teacher to improve her score
Need	Needs to get help (i.e. not me)	Because he needs to get help Try to get her help Get someone to help She needs help She's in trouble To get him better Her health and safety is important You can't just leave her like that
Sui	Suicide risk	She wants to kill herself Are you having suicidal thoughts?
Conf	Keep it confidential (even if telling adult)	A secret
Wors	Could get worse / Act if it gets worse	… if it gets worse Could get worse I would never forgive myself if s/t happened What is he going to do next? So he doesn't do something he'll regret
Unc	Unclear answer	Convince her it would be a good idea Take the L Because it can affect her lifestyle Explain what happened Tell him to choose the right option

Appendix L

Stages of Thematic Analysis

Stage [a]	Analysis of current study
1. Familiarisation with data.	I transcribed audio recordings of focus groups, and re-listened to check transcript accuracy. I took initial analytic notes.
2. Generation of initial codes.	Initial codes were made based on the RQs and focus group questions (Appendix M). Codes for each PSI-type were kept separate. Within broad initial codes, more detailed sub-codes were identified, supported by NVIVO Version 12.3.0 software.
3. Generation of candidate themes.	a. Codes were separated by RQ and PSI-type and were organised into themes (Appendix N). Context of codes were checked in transcripts when needed. Some codes (irrelevant to the RQs) were discarded. b. Codes and initial themes were written into tables (Appendix O). Some themes were divided or combined into subthemes. PSI-types remained separate. Miscellaneous codes and themes were also identified. c. Noting that similar themes occurred across the PSI-types, I decided to merge themes across the PSI-types, retaining PSI-specific codes to allow for comparison within each theme. PSI-specific and miscellaneous themes and subthemes were grouped into over-arching themes and subthemes (Appendix P). d. I made thematic maps for each RQ, exploring relationships between themes and subthemes (Appendix Q).
4. Review of themes.	a. For each RQ, overarching themes were compared against original codes. Some changes to codes included under each theme or subtheme were made. Some changes were made to theme and subtheme names. b. I re-read all transcripts, making reference to the thematic maps, to ensure that the thematic map worked well across the data set. Themes and subthemes were found to reflect the codes and original data.
5. Definition and naming of themes.	I wrote short definitions and working titles of each theme and subtheme. Some quotations from the data set and links to research literature were included.
6. Production of report.	The final report was produced from the Stage 5 notes.

[a] Stages are based on Terry et al.'s (2017) phases of thematic analysis.

Appendix M

Examples of Coded Transcripts

Figures M1-M3 provide samples of coded transcripts, taken from one of the focus groups.

Figure M1
Coded transcript: Sample 1

M: No.

F: I feel like it's more awkward at secondary because it's like there's like more age groups, like older people, there's more people.

R: Yeah so why does that make it more awkward?

F: Because like there's some people in this school that judge you just by how you look, and like they don't know you really personally, so if you go up to like that bench or a post, they're just going to like look at you and think, 'ah she has no friends.'

M: Then it's driven by stigma

R: Yeah stigma, like we were talking about.

F: I was talking.

[Laughter]

R: Are you finished?

M: Are you done?

R: Can you expand on that idea of stigma a little bit?

M: Well I'd say the older years are more judgemental, and considering like, if they have bad company around them for example, they're going to get driven and they're going to have bad influences. And since like in secondary, everyone has to like look their best and they like if, I'm saying just if you look like a specific type of person that is genuinely described in for example like cartoons, like nerdy type person, and you like sit down on a bench, people are going to think exactly that of you, like they don't even know you.

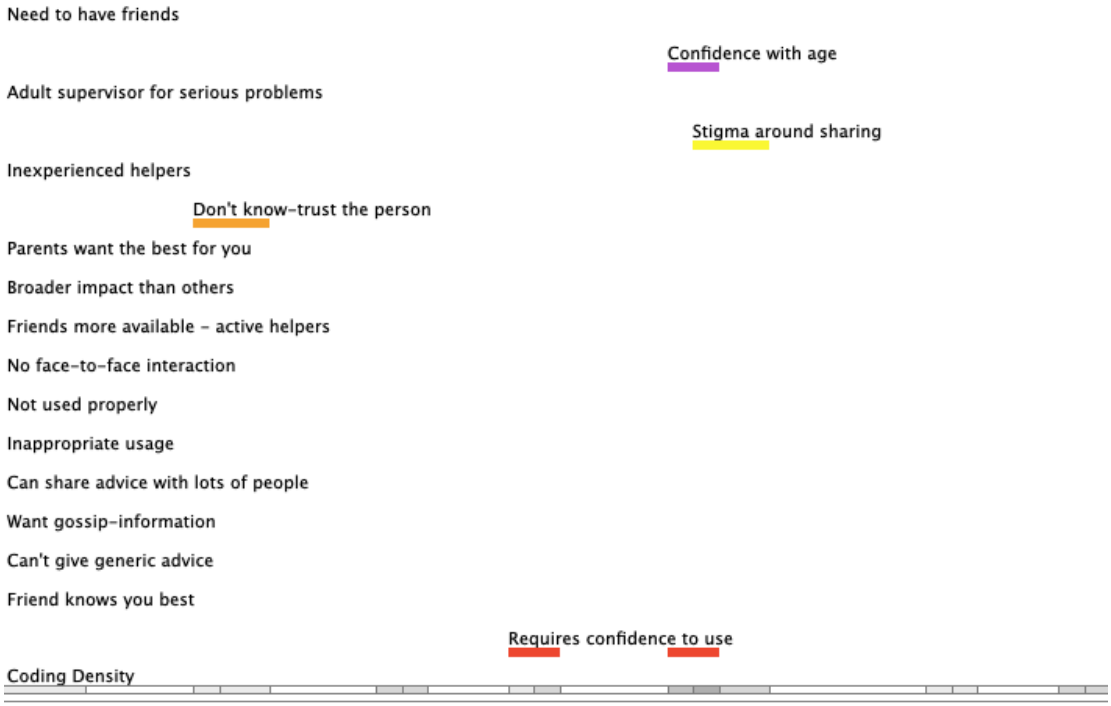
R: Yeah so they're going to make assumptions about you if you're sitting on that bench, that might not be very positive. Ok any other thoughts on those sort of things that school set up to to try and like help young people to help each other?

F: I feel like teachers and students like don't really care. They just want to know your business.

[Laughter]

R: They just want to know your business. Really?

Figure M2
Coded transcript: Sample 2



R: Yeah, yes.

M: Because they could go out and tell other students what's happening in your life.

R: Yeah so they could go and share that problem with other people. Ok, anyone else think that this system wouldn't be used very much? Ok who –

F: Sometimes you don't, there's like people that that you don't trust and you can like, you might want to tell them like your life. I don't, I want to tell somebody but I don't like trust that person.

R: Ok again so it's a case of like trusting these people. Ok. Who thinks that it would be used and that some people would use it? Yes. Why do you think that?

F: I was thinking like Year 7s or primary school children, because they don't know right from wrong, they don't know whether they're meant to share the information or not, so.

R: Ok. X where do you stand on this? Do you think people would use it or not?

M: I'm like in the middle, because like X said some people might not have confidence to talk about their problems, but then some people would probably go to it to get help.

R: Ok. So who would it be good for? If anyone were going to use it, what sort of person would use this system?

M: People old enough to be confident and speak to people they don't know, or they might know what it's from(?), but not people too young to be shy like not share their problems. It's that balance between old and trusting, but not too old because they might not want to use that because of the stigma around just sharing it with your friends or people you know.

R: Ok so people that are old enough to feel confident but young enough to not be kind of put off by the stigma thing. Ok any other thoughts on who would actually use this kind of system? Who might it be helpful for? Or would absolutely no-one ever show up to this this system? Yeah.

F: I think it would be useful for more like secondary school, but like confidential, because it would be awkward if someone sees you like walking up to them.

R: Yeah so it would need to be like in a private space maybe, ok. Thank you.

F: They say it's confidential but it's never confidential.

Figure M3
Coded transcript: Sample 3

M: I mean yeah it's useful because it's not face-to-face, it's none of that shyness issue. But again it's the lack of confidentiality, like the adult will definitely take something they see and probably escalate it if they think they should.

R: And is that a good thing or a bad thing?

M: That is not a good thing because if you're doing it online and you're talking to your friends, you want it to stay between them, and then you want a solution from them, just stay between you, and if there is no solution then maybe the adult will take it if it's being overseen by them.

R: Ok. X what did you think?

F: I forgot what I was going to say now. I remember. Are the people going to be like anonymous, like could, you could make a fake account and it could help.

R: Yeah so it's up to you. Do you think it would be better if it was all anonymous? If it didn't have names on it?

M: I think it's better with adults.

M: Remove the adult.

R: Remove the adult completely?

M: Well not completely remove the adult I'd say. I mean if you had anonymous usernames that would be better, but because the adult could be there to supervise the chat to like stop people like being negative towards each other in that sense, but if you had anonymous usernames that would, that would kind of be redundant.

R: Ok so we're thinking it sounds quite good if we make it anonymous somehow.

M: Yeah.

R: Ok what about the adult being involved? So X you weren't sure about having an adult involved at all.

M: Maybe moderators.

R: Like adult moderators? Or could young people do that as well?

Appendix N

Organisation of Codes into Themes

Figures N1-N4 display the process of organising initial codes into themes. At this stage, each PSI-type was analysed separately.

Figure N1

Organisation of codes into themes: RQ2.1

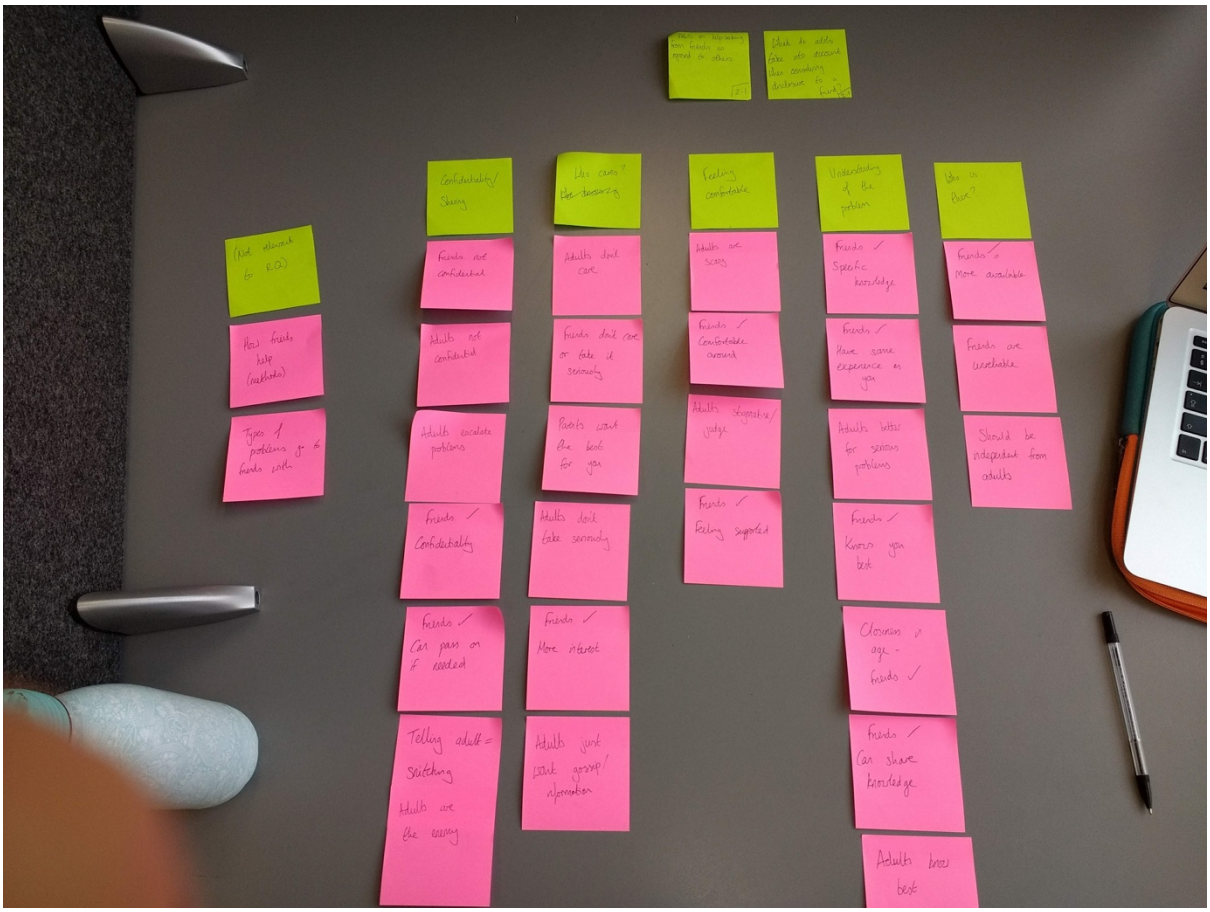


Figure N2

Organisation of codes into themes: RQ2.2 Organised PSI

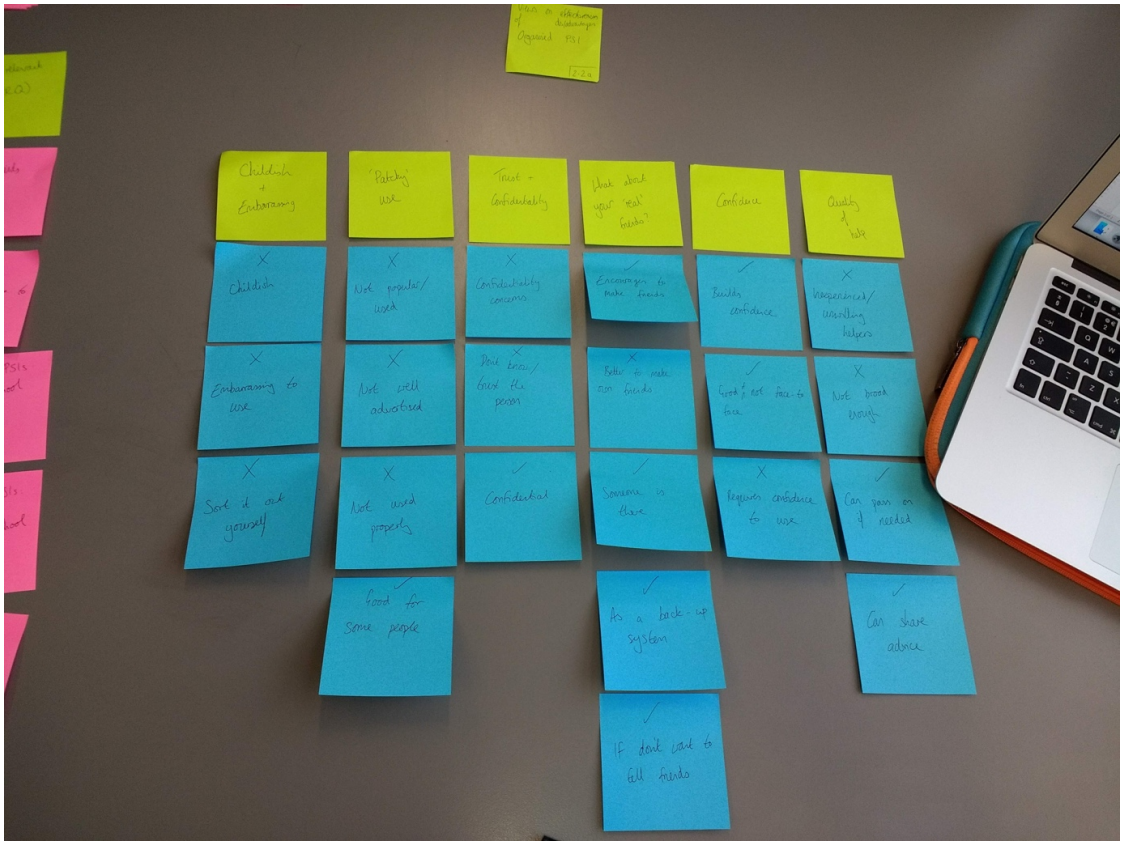


Figure N3

Organisation of codes into themes: RQ2.2 Online PSI

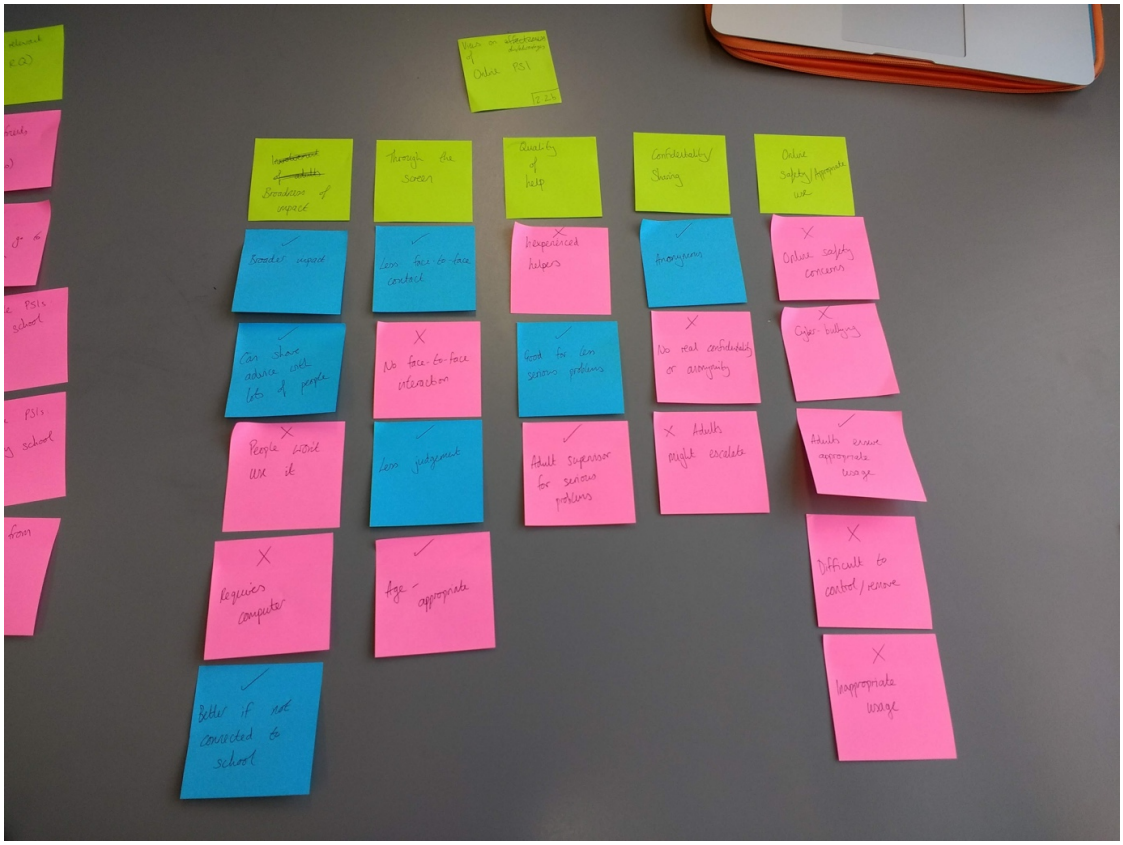
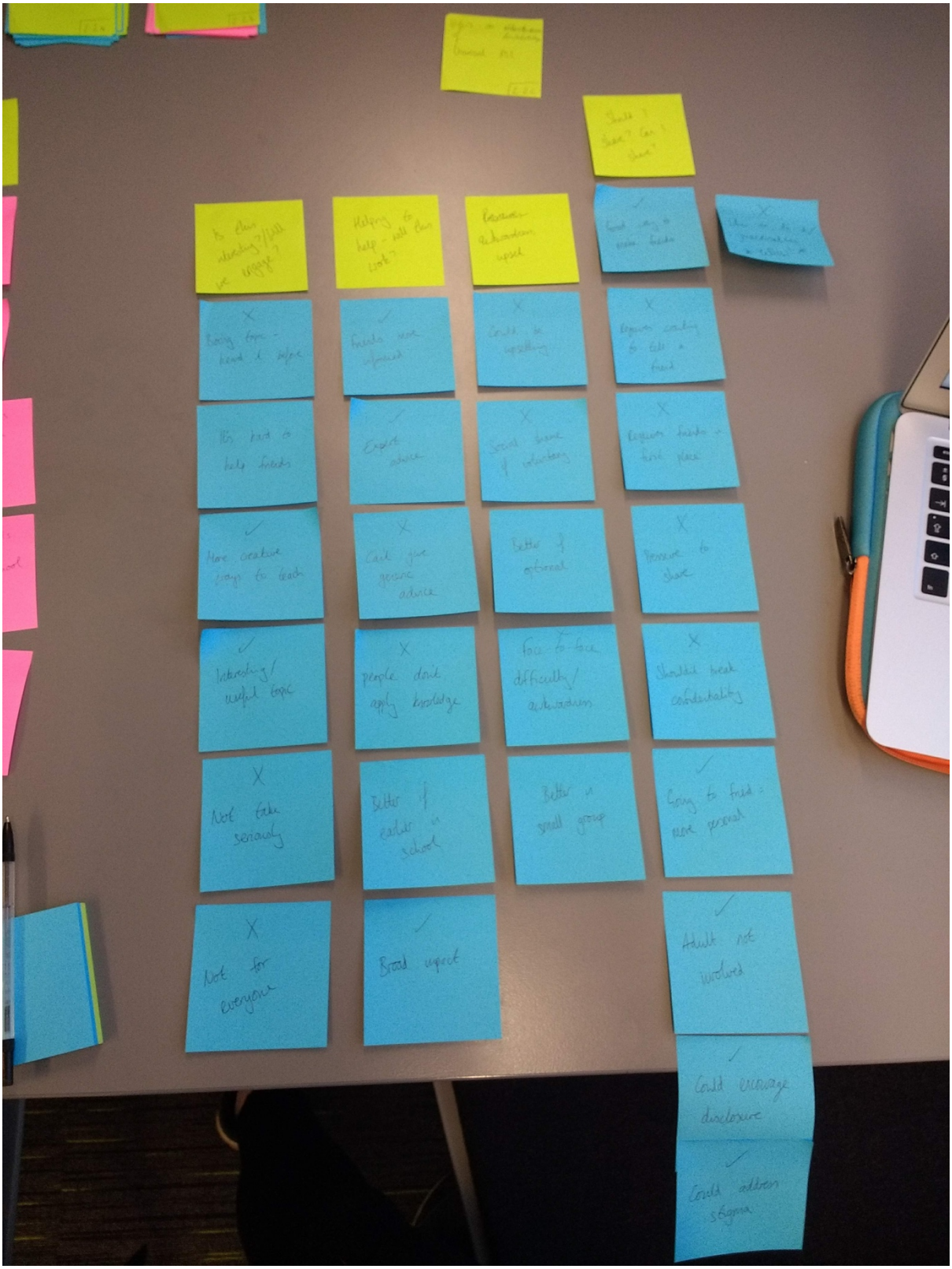


Figure N4

Organisation of codes into themes: RQ2.2 Universal PSI



Appendix O

Codes and Initial Themes and Subthemes (PSIs Separate)

This appendix displays the codes and initial themes and subthemes which were identified as part of the thematic analysis of Phase 2. Table O1 displays the themes and subthemes identified in answer to RQ2.1. Tables O2-O5 display themes and subthemes in answer to RQ2.2. At this stage, each PSI was analysed separately. Themes and subthemes were later merged, as similar themes emerged for each PSI (see Appendix P).

Table O1
Initial themes and subthemes for RQ2.1

Theme	Subthemes	Code
Confidentiality and sharing	*Who will keep my secret?*	Friends not confidential Adults not confidential Friends good = confidentiality
	Escalation	Adults escalate problems Friends good = can pass on if needed
	Keep the adults out of it	Telling adult = snitching Adults are the enemy Should be independent from adults
Why would they listen?	*Who cares about my problem?*	Adults don't care Friends don't care / take seriously Adults don't take seriously Friends good = more interest
	Motivations for listening	Parents want the best for you Adults just want gossip/information
Feeling comfortable	*Comfort of friends*	Friends = comfortable around Friends good = feeling supported
	Risks of adults	Adults stigmatise/judge Adults are scary
Understanding the problem	*Friends 'get' it'*	Friends good = specific knowledge Friends good = same experience as you Friends good = closeness in age Friends good = can share knowledge Friends good = know you best
	Adults know best	Adults better for serious problems Adults know best
Who is there?	*Friends are available*	Friends good = more available

Table O2

Initial themes and subthemes for RQ2.2: Organised PSIs

Theme	Subthemes	Code
Childish or embarrassing – 'grow up'?	*Childish*	Childish = bad
	Embarrassing	Embarrassing to use = bad
'Patchy' use / Fit for purpose?	*Who would use it?*	Not popular/used = bad Not well advertised = bad Good for some people = good
	Inappropriate use	Not used properly = bad
	Confidence	Builds confidence = good Good if not face-to-face Requires confidence to use = bad
Trust and confidentiality	*Limited confidentiality*	Confidentiality concerns = bad Confidential = good
	Why should I trust you?	Don't know/trust the person = bad
What about your 'real' friends?	*Why use a system?*	Sort it out yourself = bad Better to make own friends = bad
	Just in case…	Someone is there = good As a back-up system = good If you don't want to tell your friends = good Encourages you to make friends = good
Quality of help	*Will they help me?*	Inexperienced/unwilling helpers = bad Can pass on if needed = good
	Sharing advice	Not broad enough = bad Can share advice = good

Table O3

Initial themes and subthemes for RQ2.2: Online PSIs

Theme	Subthemes	Code
Broadness of impact	*Potential*	Broader impact = good Can share advice with lots of people = good Better if not connected with school
	Limitations	Requires computer = bad People won't use it = bad
Through the screen	*Is face-to-face interaction better?*	Less face-to-face contact = good No face-to-face interaction = bad Less judgement = good
	Technology generation	Age-appropriate = good
Quality of help – Can they handle the problems?	----	Inexperienced helpers = bad Good for less serious problems Adult supervisor for serious problems
Confidentiality and sharing	----	Anonymous = good No real confidentiality or anonymity Adults might escalate = bad
Online safety / Appropriate use	*Controlling the beast*	Difficult to control/remove = bad Adults ensure appropriate usage = good Inappropriate usage = bad
	Feeling safe online?	Cyber-bullying = bad Online safety concerns = bad

Table O4

Initial themes and subthemes for RQ2.2: Universal PSIs

Theme	Subthemes	Code
Will we engage?	*Is it interesting to us?*	Boring topic – heard it all before Interesting/useful topic It's hard to help friends More creative ways to teach it
	Who cares?	Not take it seriously Not suitable for everyone Broad impact = good People don't apply knowledge = bad Better if earlier in school
Helping to help – will this work?	----	Friends more informed = good Expert advice = good Can't give generic advice = bad
Awkwardness and upset	----	Could be upsetting = bad Social shame if voluntary = bad Better if optional Better in a small group
Sharing with a friend – Can I? Should I?	*Is it possible?*	Good way to make friends = good Requires friends in the first place = bad
	Do I want to?	Face-to-face difficulty/awkwardness = bad Requires wanting to tell a friend = bad Going to friend is more personal = good Adult not involved = good Could encourage disclosure = good Could address stigma = good
	Do I have to?	Pressure to share = bad Shouldn't break confidentiality
Practicalities	----	When to have the lesson?

Table O5

Initial themes and subthemes for RQ2.2: Miscellaneous codes

Theme	Subthemes	Code
The right to remain silent	----	Embarrassing to share problems Don't pressurise me to share Prefer not to share Stigma around sharing
My generation (age-appropriate)	*Mental health and us*	Anxious generation Better understanding of MH Tired of hearing about MH
	Misunderstood and unheard	Listen to us Misunderstood generation
	Technology	Technology
Growing up (age-appropriate)	*Dealing with stress*	Confidence comes with age Higher stress with age
	Social cruelty	Cruelty comes with age Peer pressure / social standards
	From primary to secondary	Low take-up / less need for PSIs in secondary Nostalgia for primary

Appendix P

Combination of PSI-Specific Analyses

As part of the Phase 2 thematic analysis, each PSI was initially analysed separately (Appendix O). After I noticed that similar themes emerged across each PSI, I decided to merge the analyses. I felt that this would make the analysis more concise and allow for easier comparison of the three PSI-types. Table P1 demonstrates how PSI-specific themes and subthemes were merged into overarching themes. Thematic analysis was treated as an iterative process with frequent review; the themes and subthemes here are therefore not the final themes and subthemes presented in the analysis in Section 6 of this thesis.

Table P1

Combination of PSI-specific themes and subthemes into overarching themes

Overarching themes	PSI-specific themes	Subthemes
Age-appropriate	*Misc [a]: My generation*	Mental health and us Misunderstood and unheard Technology
	Misc: Growing up	Dealing with stress Social cruelty From primary to secondary
	Org [b]: Childish	Childish Embarrassing
	Onl [c]: Through the screen	Technology generation
Quality of help	*Org: Quality of help*	Will they help me? Sharing advice
	Onl: Quality of help	Can they handle problems?
	Uni [d]: Helping to help	Will this work?

Confidentiality and sharing	*Onl: Confidentiality and sharing*	Confidentiality/Sharing
	Org: Trust and confidentiality	Limited confidentiality Why should I trust you?
	Uni: Should I share?	Is it possible to share? Do I want to share? Do I have to share?
	Misc: Right to remain silent	The right to remain silent
Fitness for purpose / Appropriate use	*Org: Fit for purpose*	Inappropriate use
	Onl: Online safety / Appropriate use	Controlling the beast Feeling safe online
	Uni: Will we engage?	Who cares?
Will we use it? / Popularity	*Org: Patchy use* *Org: What about real friends?*	Who would use it? Why use a system? Just in case…
	Onl: Breath of impact	Potential Limitations
	Uni: Will we engage?	Is it interesting to us?
	Org: Quality of help	Sharing advice
	Uni: Practicalities	Practicalities
Avoiding awkwardness	*Onl: Through the screen*	Is face-to-face better?
	Uni: Awkwardness and upset	Awkwardness and upset
	Org: Patchy	Confidence

[a] Themes originally categorised as “miscellaneous” (Table O5)
[b] Themes originally categorised in relation to organised PSIs (Table O2)
[c] Themes originally categorised in relation to online PSIs (Table O3)
[d] Themes originally categorised in relation to universal PSIs (Table O4)

Appendix Q

Thematic Maps

Figures Q1-Q2 display the thematic maps for RQs 2.1 and 2.2.

Figure Q1

Thematic map for RQ2.1

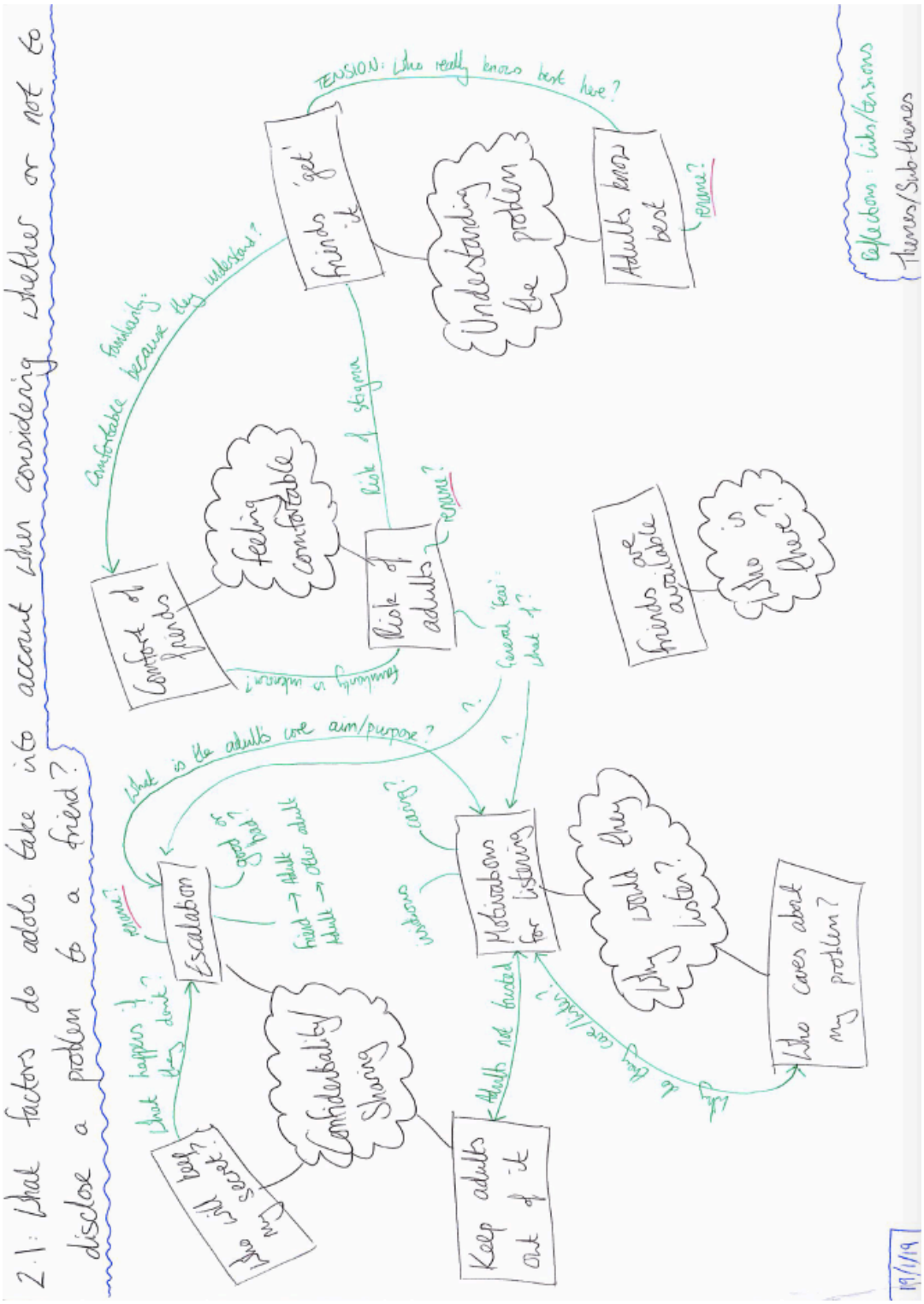
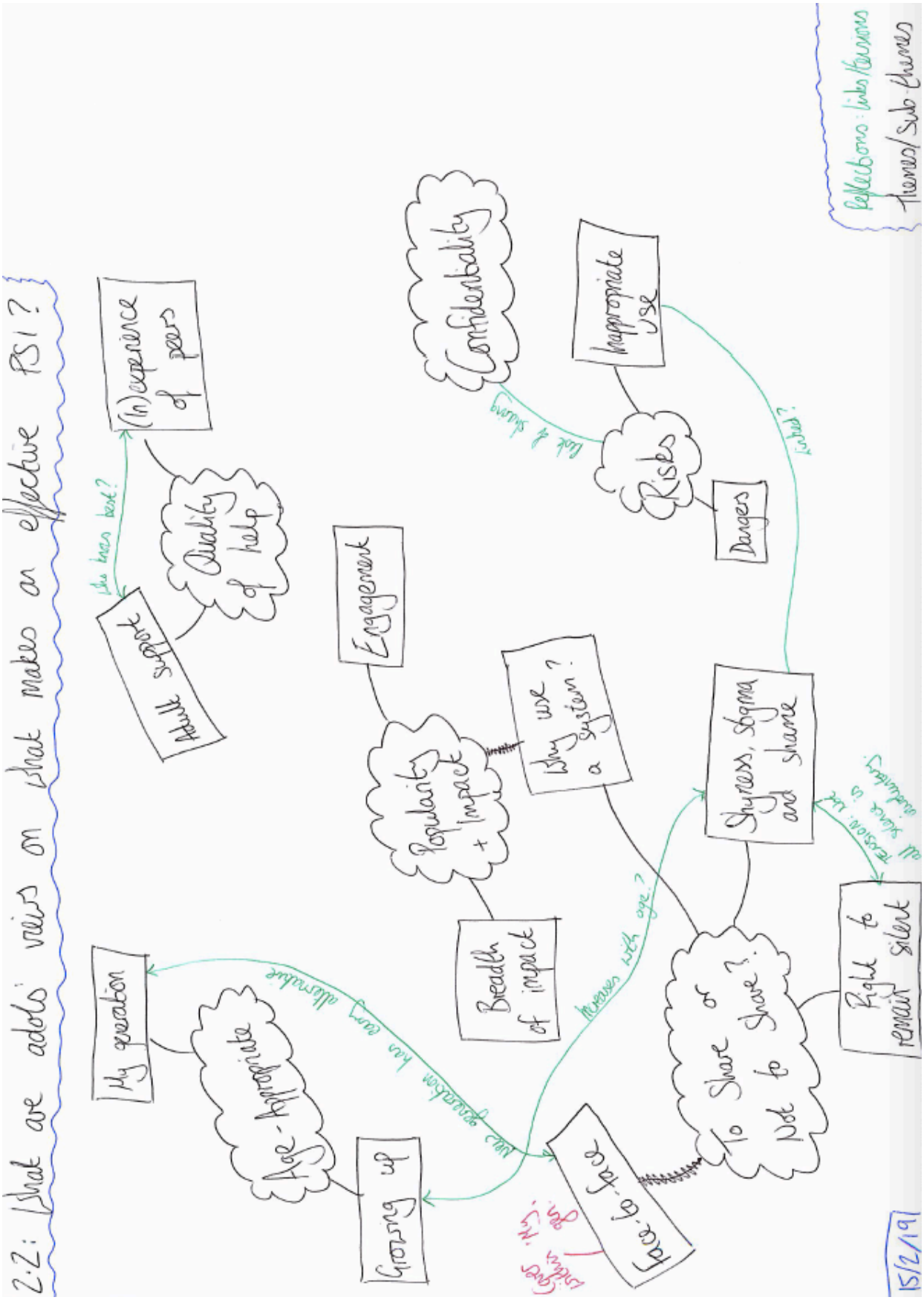


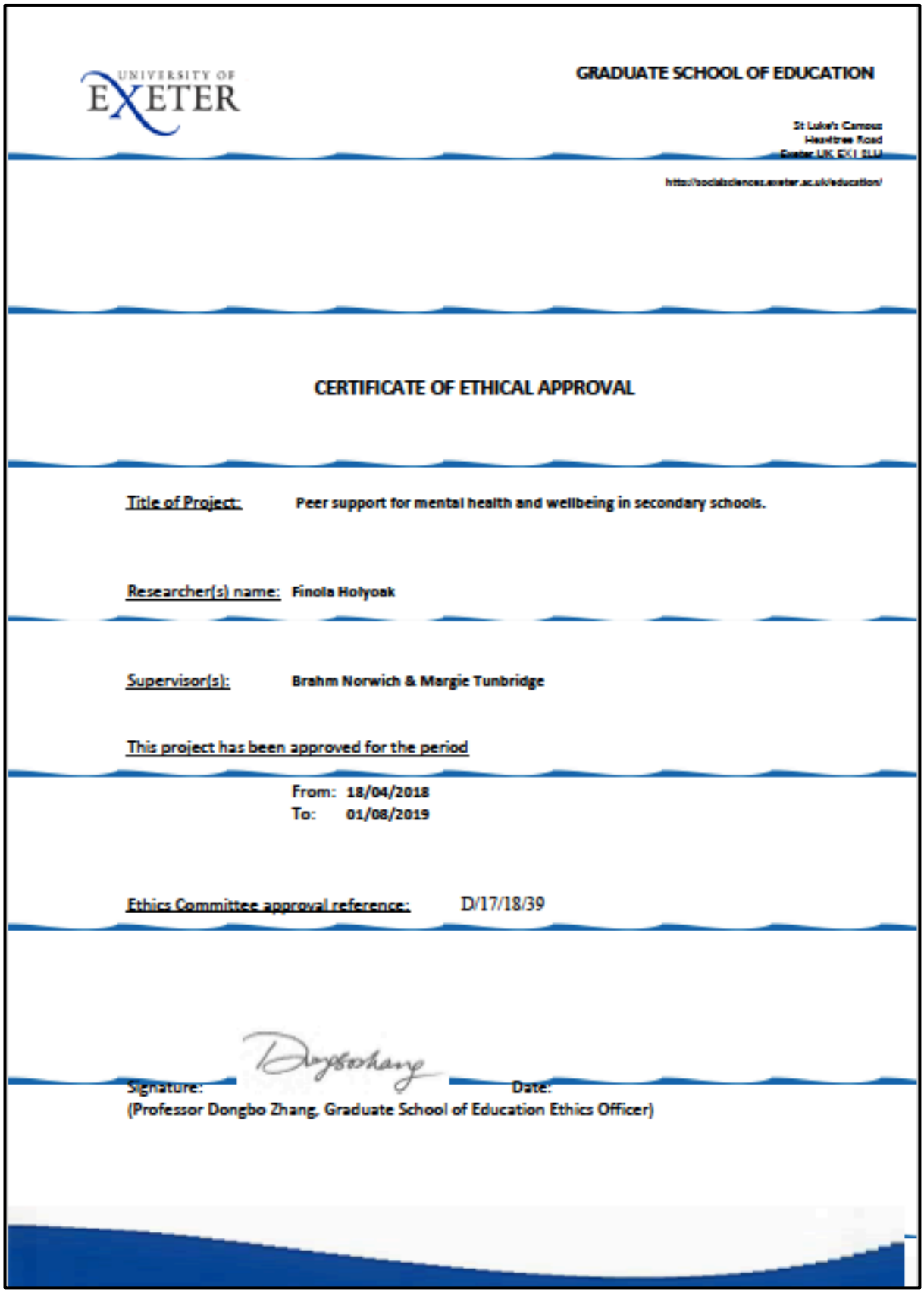
Figure Q2

Thematic map for RQ2.2



Appendix R

Certificate of Ethical Approval



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CERTIFICATE OF ETHICAL APPROVAL

Title of Project: Peer support for mental health and wellbeing in secondary schools.

Researcher(s) name: Finola Holyoak

Supervisor(s): Brahm Norwich & Margie Tunbridge

This project has been approved for the period

From: 18/04/2018
To: 01/08/2019

Ethics Committee approval reference: D/17/18/39

Signature: Dongbozhang Date:
(Professor Dongbo Zhang, Graduate School of Education Ethics Officer)

Appendix S

Sections From Ethical Approval Form

This appendix displays selected sections from the ethical approval form submitted to the university. I have included sections which required assessment of possible ethical considerations for the research project. Several changes were made to the research process after the form had been submitted, through discussion with supervisors. These changes are outlined in footnotes throughout this appendix.

The Voluntary Nature of Participation

Phase 1.

An information and consent form will be sent to all parents of children in Year 9 at least one week prior to the young people completing the questionnaire. Passive consent for participation will be gained. Parents will be asked to return a slip to say that they do **not** give consent for their child to participate. Parents can also refuse participation by phoning the school or emailing the researcher.

Written into the beginning of the questionnaire will be an explanation for the students that their participation is voluntary. Participants will sign a statement on the first page of the questionnaire to indicate their understanding and assent.[1] The researcher will be present for the administration of the questionnaire, and will reinforce this message verbally before the questionnaire is administered. Staff who are present for the administering of the questionnaire will be made aware of the importance of the young people understanding the voluntary nature of their participation. On the day of completing the questionnaire, young people will be given an alternative activity to do (e.g. reading) if they do not wish to take part, and staff will be informed that there should be no punishments (verbal or otherwise) for choosing not to participate.

[1] After the implementation of GDPR, participants signed their assent on a separate sheet of paper.

Phase 2.

Participants will be selected based on their agreement to participate in Phase 2 (as stated in the Phase 1 questionnaire). A letter will be sent to parents explaining that their child has volunteered and subsequently been selected for participation in Phase 2, involving group interviews.[2] Active consent for their child to participate will be gained by parents returning a permission slip to the school, stating their willingness for their child to participate.

The focus groups will be run by the researcher. At the beginning of the focus groups, participants will be informed verbally that their participation is voluntary. They will also sign an assent form showing their agreement to participate. They will be given an alternative activity to do (e.g. returning to class) if they do not wish to take part in the focus group.

Special Arrangements

Extra help, such as readers and scribes, will be arranged for those who find reading and writing challenging. This will be arranged via the school SENCo. Staff providing support will be asked by the researcher to respect the confidentiality of the participant's answers.

Informed Nature of Participation

Pilot study.

The participants and parents will be informed prior to participation that the study is taking place for piloting purposes, and that their data will not be analysed as part of the research. If any pilot participants subsequently request to have their data included in the research study, it will sensitively be explained that this will not be possible due to the anonymity of the pilot questionnaires, and the fact that the focus group was not audio recorded.

[2] Due to recruitment difficulties and organisational issues within the schools, participants were not given the opportunity to volunteer for Phase 2, as the questionnaire administration and focus groups were completed on the same day. Instead, the school-link selected Year 9 students with an even split of genders and a range of academic abilities to take part.

Phase 1.

Information about the purpose and nature of the study, including how the data will be used, will be sent to parents at least one week prior to the young people completing the questionnaire.

Written into the beginning of the questionnaire will be information for the participants about the nature and purpose of the study, including how the data will be used (i.e. as part of a doctoral thesis, and possibly in conference presentations and publication in an academic journal). The researcher will also give this information verbally before the participants begin the questionnaire. Participants will sign a statement on the first page of the questionnaire to indicate their understanding and assent.

Participants will be informed of their right to withdraw at any time during the administration of the questionnaire. They will be given a period of one week to contact the researcher (through the school SENCo) to request that their answers be withdrawn from the study. They will be informed that this will not be possible if they did not add their name to the questionnaire. If possible, the paper questionnaire will be destroyed and data will not be included in the analysis. Data will be anonymised and input into SPSS after this deadline for withdrawal has passed. Participants will be told that after this period, their request will not be possible due to the anonymization of the data.

Phase 2.

In the Phase 1 questionnaire, a short description of the nature of Phase 2 will be provided, and participants will have the opportunity to volunteer. It will be explained that not all participants who opt in will be selected to take part.[3]

At the beginning of the focus group, participants will be informed verbally by the researcher of the nature and purpose of the focus group, including how the information they provide will be used. They will also sign an assent form containing this information, to indicate assent to participate.

Before the focus group starts, participants will be verbally informed of their right to withdraw at any time during the focus group. They will be given a period of one

[3] See Footnote 2

week to contact the researcher (through the school SENCo) to request that their answers be withdrawn from the study. In this instance, the individual contributions of that person will be removed from the transcript and subsequent analysis as far as possible. This may be challenging due to the difficulty of distinguishing between participants in focus group audio recordings. Participants will be informed that if they choose to withdraw their data, the researcher will make her best efforts to remove that individual's data from the study, but complete removal may not be possible. If a participant requests withdrawal, he/she will be asked if there is a specific contribution which he/she would like to have removed. This would then be removed from the transcript and subsequent analysis. Data will be anonymised and input into NVIVO after this deadline for withdrawal has passed. Participants will be told that after this period, their request will not be possible due to the anonymization of the data.

Assessment of Possible Harm

Potential distress: Phase 1.

One possible risk is that the sensitive content of the questionnaire may evoke some emotional distress for certain young people.

In order to reduce distress, the content of the questionnaire will offer hypothetical situations through the use of vignettes, rather than asking participants to give detailed descriptions of their personal experiences. Participants will be asked to describe the type of peer disclosures they have experienced very briefly and in little detail (just two or three words).

The rationale for providing participants with these vignettes is based on research showing that young people discuss problems with one another, and primarily rely on their peers for support during difficult times. Considering the prevalence of mental health difficulties among young people (which is well-documented in research on this area), it is likely that participants will have already had some exposure to the mental health difficulties raised in the vignettes. It is therefore felt that the content of the vignettes is unlikely to be entirely unfamiliar to the participants. The content of the vignettes is taken from research on the experiences of young people who have experienced each mental health difficulty.

Potential distress: Phase 2.

It is unlikely that the content of the focus groups will cause distress, as they will be focused on peer support interventions supporting mental health rather than personal experiences. Nevertheless, the subject of mental health may cause difficulties for some young people.

Measures to address potential distress.

- Information sent to parents will include a description of the content of the questionnaire and focus groups, including the fact that specific mental health difficulties will be raised in the questionnaire.
- All school staff working with Year 9 will be informed by email of the nature of the questionnaire and focus groups, so that they can be prepared for any subsequent distress.
- Before the questionnaire and focus groups are administered, the researcher will discuss with the SENCo whether the content of the study is likely to be distressing to any of the participants. As each questionnaire will include only two mental health difficulties (of a possible four), it might be that the questionnaire can be delivered without reference to particular problems experienced in the participating class (according to the knowledge of the SENCo).
- The questionnaire will not be administered if the SENCo is concerned that significant distress could be caused.
- If there are significant concerns about an individual's participation in the focus group, another participant will be selected. If there are minor concerns, the researcher will take care in addressing particular themes during the focus group. It is felt that since the young person will have volunteered to take part, she/he should be allowed to take part in the focus group unless there are significant concerns about her/his ability to participate.
- Before administration, the researcher will give a 'health warning' about the content of the questionnaire/focus group. The participants will be informed that they have no obligation to complete the questionnaire, and will sign their assent to show understanding of this.
- A member of staff will be designated before the administration of the questionnaire and focus groups as somebody to whom the participants can

go if they have become distressed. This member of staff will be informed about the nature of the study and his/her designated role.

- It will be explained verbally before the administration of the questionnaire and focus groups that participants should talk to the designated member of staff or phone Childline if they would like to talk to someone about anything that upset them in the questionnaire or focus group. The number for Childline will be given at the end of the questionnaire.
- The researcher is a doctoral trainee educational psychologist with experience and training in dealing with distress in children. During the focus groups and questionnaire administration, the researcher will be present to comfort and listen to any young person who becomes distressed. The researcher will also be able to signpost the distressed young person to relevant services and professionals.
- The researcher will report any instances of distress caused during the focus groups or questionnaires to the SENCo, with the permission of the young person.
- The researcher will request that school staff report any occurrences of distress caused by the questionnaire or focus groups (either on the day or subsequent to the administration). The researcher will then be able to offer support and advice to school staff on how best to support the distressed young person, in her capacity as a trainee educational psychologist at the local authority's Educational Psychology Service.

The researcher has enhanced DBS clearance through the university.

Data Protection and Storage

Pilot study.

The completed pilot questionnaires will be anonymous, and will be destroyed within six months of completion. The pilot focus group will not be audio recorded, and therefore no data for this focus group will exist. Data from the pilot study will not be included in the data analysis.

Phase 1.

Participants will not be asked to put their names on the questionnaire, and their answers will therefore be anonymous. Participants will only be asked to include their names if they wish to volunteer for Phase 2 of the study. Their names may also be readable from signing assent on the first page of the questionnaire. In these cases, their answers will be treated as confidential.[4]

Completed questionnaires will be collected by the researcher and stored in a locked cabinet in the researcher's home. Only the researcher will have access to the key to the cabinet. The paper copies of the questionnaires will be destroyed within two years.

Data will be transferred from the paper questionnaires to SPSS without names or personal details attached to raw data. The SPSS data file will be saved in a password protected folder (with 'administrator only' permission) on a password protected computer and backed up on a secure server. It will be deleted permanently within two years. Data will be reported anonymously.

Phase 2.

The participants will be asked not to share any views expressed in the focus group outside of the room, to respect the confidentiality of the other participants. Participants in each focus group will be asked to sign an assent form including a confidentiality agreement, to formalise the procedure of ensuring confidentiality.

Focus groups will be recorded using audio recording software on a password protected computer. Voice data will be kept for transcription purposes in a password protected folder (with 'administrator only' permission) on a password protected computer, backed up on a secure server. Voice data will be deleted within two years. Focus group transcriptions will not contain any names or identifiable data. Data will be transferred to NVivo without names or identifiable details attached to raw data. All research will be presented in anonymised form, with any identifiable information removed or changed.

[4] After the implementation of GDPR, any identifiable data (such as email addresses and signatures) were on a sheet separate to the questionnaire, in order to ensure the anonymity of the questionnaires.

If it is possible to identify individual participants through the focus group audio recordings, participants will be allocated a pseudonym by the researcher, chosen via an online random name generator. If participants request to have their real names used in the research, they will be informed that this is not possible, in order to protect the identity of the other participants.

Participating schools.

The participating schools will be reported anonymously: they will be described in the research only in terms of their demographic information. It is possible that readers may be able to deduce the local authority to which the schools belong by searching the job history of the researcher. However, there will be no further identifying information regarding specific participating schools.

User Engagement and Feedback

Phases 1 and 2.

At the end of the questionnaire and focus groups, participants will be asked if they would like to receive a summary of the overall findings of the questionnaire (from all participating schools) by email. Their email address will be requested if so.

At the end of the research process, each school will receive a summary of the overall findings of the questionnaire and focus groups, using data from all participating schools. They will also receive a summary of information which the researcher feels may be useful in informing future peer support interventions.

Phase 2.

Participants will be aware of their commitments to research and the data they are producing, so the researcher does not foresee a need to share final transcripts with participants unless specifically requested.